APPENDIX D
SAMPLE FORMS

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SAMPLE FORMS

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VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

Dates:
Screen: ____/____/____
Assessment: ____/____/____
Re-assessment: ____/____/____

1 IDENTIFICATION/BACKGROUND

Name & Vital Information

Client Name: _____ Client SSN: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City) (State) (Zip Code)

Phone: _____ City/County Code: _____

Directions to House: **Pets?**

Demographics

Birthdate: ____/____/____ **Age:** _____ **Sex:** ____ Male 0 ____ Female 1
(Month) (Day) (Year)

Marital Status: ____ Married 0 ____ Widowed 1 ____ Separated 2 ____ Divorced 3 ____ Single 4 ____ Unknown 9

Race:
____ White 0
____ Black/African American 1
____ American Indian 2
____ Oriental/Asian 3
____ Alaskan Native 4
____ Unknown 9 _____
Ethnic Origin: _____

Education:
____ Less than High School 0
____ Some High School 1
____ High School Graduate 2
____ Some College 3
____ College Graduate 4
____ Unknown 9
Specify: _____

Communication of Needs:
____ Verbally, English 0
____ Verbally, Other Language 1
Specify: _____
____ Sign Language/Gestures/Device 2
____ Does Not Communicate 3
Hearing Impaired? _____

Primary Caregiver/Emergency Contact/Primary Physician

Name: _____ Relationship: _____
Address: _____ Phone: _____ (H) _____ (W) _____
Name: _____ Relationship: _____
Address: _____ Phone: _____ (H) _____ (W) _____
Name of Primary Physician: _____ Phone: _____
Address: _____

Initial Contact

Who called: _____
(Name) (Relation to Client) (Phone)

Presenting Problem/Diagnosis:

Client Name: *Client SSN:*

Current Formal Services

Do you currently use any of the following types of services?

No 0	Yes 1	*(Check All Services That Apply)*	Provider/Frequency:
		Adult Day Care	
		Adult Protective	
		Case Management	
		Chore/Companion/Homemaker	
		Congregate Meals/Senior Center	
		Financial Management/Counseling	
		Friendly Visitor/Telephone Reassurance	
		Habilitation/Supported Employee	
		Home Delivered Meals	
		Home Health/Rehabilitation	
		Home Repairs/Weatherization	
		Housing	
		Legal	
		Mental Health (Inpatient/Outpatient)	
		Mental Retardation	
		Personal Care	
		Respite	
		Substance Abuse	
		Transportation	
		Vocational Rehab/Job Counseling	
		Other:	

Financial Resources

Where are you on the scale for annual (monthly) family income before taxes?

	$20,000 or More	($1,667 or more) 0
	$15,000 - 19,999	($1,250 - $1,666) 1
	$11,000 - 14,999	($ 917 - $1,249) 2
	$ 9,500 - 10,999	($ 792 - $ 916) 3
	$ 7,000 - 9,499	($ 583 - $ 791) 4
	$ 5,500 - 6,999	($ 458 - $ 582) 5
	$ 5,499 or Less	($ 457 or Less) 6
	Unknown 9	

Number in Family unit: _____

Optional: Total monthly family income: _____

Do you currently receive income from…?

No 0	Yes 1		*Optional: Amount*
		Black Lung	
		Pension	
		Social Security	
		SSI/SSDI	
		VA Benefits	
		Wages/Salary	
		Other	

Does anyone cash your check, pay your bills or manage your business?

No 0	Yes 1		*Names*
		Legal Guardian	
		Power of Attorney	
		Representative Payee	
		Other	

Do you receive any benefits or entitlements?

No 0	Yes 1	
		Auxiliary Grant
		Food Stamps
		Fuel Assistance
		General Relief
		State and Local Hospitalization
		Subsidized Housing
		Tax Relief

What types of health insurance do you have?

No 0	Yes 1			
		Medicare, #		
		Medicaid, #		
		Pending:	No 0	Yes 1
		QMB/SLMB:	No 0	Yes 1
		All Other Public/Private:		

Client Name:	*Client SSN:*

Physical Environment

Where do you usually live? Does anyone live with you?

	Alone 1	Spouse 2	Other 3	Names of Persons in Household
____ House: Own 0				
____ House: Rent 1				
____ House: Other 2				
____ Apartment 3				
____ Rented Room 4				

	Name of Provider *(Place)*	Admission Date	Provider Number *(If Applicable)*
____ Adult Care Residence 50			
____ Adult Foster 60			
____ Nursing Facility 70			
____ Mental Health/Retardation Facility 80			
____ Other 90			

Where you usually live are there any problems?

No 0	Yes 1	*(Check All Problems That Apply)*
_____	_____	Barriers to Access
_____	_____	Electric Hazards
_____	_____	Fire Hazards/No Smoke Alarm
_____	_____	Insufficient Heat/Air Conditioning
_____	_____	Insufficient Hot Water/Water
_____	_____	Lack of Poor Toilet Facilities (Inside/Outside)
_____	_____	Lack of Defective Stove, Refrigerator, Freezer
_____	_____	Lack of Defective Washer/Dryer
_____	_____	Lack of Poor Bathing Facilities
_____	_____	Structural Problems
_____	_____	Telephone Not Accessible
_____	_____	Unsafe Neighborhood
_____	_____	Unsafe/Poor Lighting
_____	_____	Unsanitary Conditions
_____	_____	Other: _____

Describe Problems:

Client Name: *Client SSN:*

2 FUNCTIONAL STATUS *(Check only one block for each level of functioning.)*

ADLS	Needs Help?	
	No 00	Yes
Bathing		
Dressing		
Toileting		
Transferring		
Eating/Feeding		

MH Only 10 Mechanical Help	HH Only 2 D Human Help		MH & HH 3 D		Performed D by Others 40			Is Not D Performed 50
	Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2				
					Spoon Fed 1	Syringe/ Tube Fed 2	Fed by IV 3	

Continence	Needs Help?	
	No 00	Yes
Bowel		
Bladder		

Incontinent Less than Weekly 1	Ext. Device/ Indwelling/ Ostomy Self Care 2	Incontinent D Weekly or More 3	External D Device Not Self Care 4	Indwelling D Catheter Not Self Care 5	Ostomy D Not Self Care 6

Ambulation	Needs Help?	
	No 00	Yes
Walking		
Wheeling		
Stairclimbing		
Mobility		

MH Only 10 Mechanical Help	HH Only 2 D Human Help		MH & HH 3 D		Performed D by Others 40	Is Not D Performed 50
	Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
					Confined Moves About	**Confined** Does Not Move About

IADLS	Needs Help?	
	No 0	D Yes 1
Meal Preparation		
Housekeeping		
Laundry		
Money Mgmt.		
Transportation		
Shopping		
Using Phone		
Home Maintenance		

Comments:

Outcome: Is this a short assessment?

____ No, Continue with Section 3 (0) ____ Yes, Service Referrals (1) ____ Yes, No Service Referrals (2)

Screener: _____ Agency: _____

Client Name: *Client SSN:*

3 PHYSICAL HEALTH ASSESSMENT

Professional Visits/Medical Admissions

Doctor's Name(s) *(List all)*	Phone	Date of Last Visit	Reason for Last Visit

Admission: In the past 12 months have you been admitted to a . . . for medical or rehabilitation reasons?

No 0	Yes 1		Name of Place	Admit Date	Length of Stay/Reason
		Hospital			
		Nursing Facility			
		Adult Care Residence			

Do you have any advance directives such as … (Who has it … Where is it …)?

No 0 Yes 1 *Location*

_____ _____ Living Will, _____

_____ _____ Durable Power of Attorney for Health Care, _____

_____ _____ Other, _____

Diagnoses & Medication Profile

Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as … (Refer to the list of diagnoses)?

Current Diagnoses	Date of Onset

Enter Codes for 3 Major, Active Diagnoses: ____ **None00** ____ **DX1** ____ **DX2** ____ **DX3**

Current Medications (Include Over-the-Counter)	Dose, Frequency, Route	Reason(s) Prescribed
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Total No. of Medications: _____ **(If 0, skip to Sensory Function)** **Total No. of Tranquilizer/Psychotropic Drugs:** _____

Do you have any problems with medicine(s) …?

No 0 Yes 1

_____ _____ Adverse reactions/allergies

_____ _____ Cost of medication

_____ _____ Getting to the pharmacy

_____ _____ Taking them as instructed/prescribed

_____ _____ Understanding directions/schedule

How do you take your medications?

_____ Without assistance 0

_____ Administered/monitored by lay person 1

_____ Administered/monitored by professional nursing staff 2

Describe help: _____

Name of helper: _____

Diagnoses:
- Alcoholism/Substance Abuse (01)
- Blood-Related Problems (02)
- Cancer (03)
- Cardiovascular Problems
  - Circulation (04)
  - Heart Trouble (05)
  - High Blood Pressure (06)
  - Other Cardiovascular Problems (07)
- Dementia
  - Alzheimer's (08)
  - Non-Alzheimer's (09)
- Developmental Disabilities
  - Mental Retardation (10)
  - Related Conditions
    - Autism (11)
    - Cerebral Palsy (12)
    - Epilepsy (13)
    - Friedreich'a Ataxia (14)
    - Multiple Scierosis (15)
    - Muscular Dystrophy (16)
    - Spina Bifida (17)
- Digestive/Liver/Gall Bladder (18)
- Endocrine (Gland)Problems
  - Diabetes (19)
  - Other Endocrine Problem (20)
- Eye Disorders (21)
- Immune System Disorders (22)
- Muscular/Skeletal
  - Arthritis/Rheumatoid Arthritis (23)
  - Osteoporosis (24)
  - Other Muscular/Skeletal Problems (25)
- Neurological Problems
  - Brian Trauma/Injury (26)
  - Spinal Cord Injury (27)
  - Stroke (28)
  - Other Neurological Problems (29)
- Psychiatric Problems
  - Anxiety Disorder (30)
  - Bipolar (31)
  - Major Depression (32)
  - Personality Disorder (33)
  - Schizophrenia (34)
  - Other Psychiatric Problems (35)
- Respiratory Problems
  - Black Lung (36)
  - COPD (37)
  - Pneumonia (38)
  - Other Respiratory Problems (39)
- Urinary/Reproductive Problems
  - Renal Failure (40)
  - Other Urinary /Reproductive (41)
- All Other Problems (42)

Client Name: *Client SSN:*

Sensory Functions

How is your vision, hearing, and speech?

	No Impairment 0	Impairment *Record Date of Onset/Type of Impairment*		Complete Loss 3	Date of Last Exam
		Compensation 1	No Compensation 2		
Vision					
Hearing					
Speech					

Physical Status

Joint Motion: How is your ability to move your arms, fingers, and legs?

_____ Within normal limits or instability corrected 0
_____ Limited motion 1
_____ Instability uncorrected or immobile 2

Have you ever broken or dislocated any bones … ever had an amputation or lost any limbs … lost voluntary movement of any part of your body?

Fractures/Dislocations	Missing Limbs	Paralysis/Paresis
____ None 000	____ None 000	____ None 000
____ Hip Fracture 1	____ Finger(s)/Toe(s) 1	____ Partial 1
____ Other Broken Bone(s) 2	____ Arm(s) 2	____ Total 2
____ Dislocation(s) 3	____ Leg(s) 3	Describe: _____
____ Combination 4	____ Combination 4	
Previous Rehab Program?	**Previous Rehab Program?**	**Previous Rehab Program?**
____ No/Not Completed 1	____ No/Not Completed 1	____ No/Not Completed 1
____ Yes 2	____ Yes 2	____ Yes 2
Date of Fracture/Dislocation?	**Date of Amputation?**	**Onset of Paralysis?**
____ 1 Year or Less 1	____ 1 Year or Less 1	____ 1 Year or Less 1
____ More than 1 Year 2	____ More than 1 Year 2	____ More than 1 Year 2

Nutrition

Height: _____ *(Inches)* Weight: _____ *(lbs.)* Recent Weight Gain/Loss: ____ No 0 ____ Yes 1
Describe: _____

Are you on any special diet(s) for medical reasons?

___ None 0
___ Low Fat/Cholesterol 1
___ No/Low Salt 2
___ No/Low Sugar 3
___ Combination/Other 4

Do you take dietary supplements?

___ None 0
___ Occasionally 1
___ Daily, Not Primary Source 2
___ Daily, Primary Source 3
___ Daily, Sole Source 4

Do you have any problems that make it hard to eat?

No 0	Yes 1	
____	____	Food Allergies
____	____	Inadequate Food/Fluid Intake
____	____	Nausea/Vomiting/Diarrhea
____	____	Problems Eating Certain Foods
____	____	Problems Following Special Diets
____	____	Problems Swallowing
____	____	Taste Problems
____	____	Tooth or Mouth Problems
____		Other: _____

Client Name: *Client SSN:*

Current Medical Services

Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as … ?

No 0	Yes 1		*Frequency*
		Occupational	
		Physical	
		Reality/Remotivation	
		Respiratory	
		Speech	
		Other	

Do you have pressure ulcers?

		Location/Size
	None 0	
	Stage I 1	
	Stage II 2	
	Stage III 3	
	Stage IV 4	

Special Medical Procedures: Do you receive any special nursing care, such as … ?

No 0	Yes 1		*Site, Type, Frequency*
		Bowel/Bladder Training	
		Dialysis	
		Dressing/Wound Care	
		Eye care	
		Glucose/Blood Sugar	
		Infections/IV Therapy	
		Oxygen	
		Radiation/Chemotherapy	
		Restraints (Physical/Chemical)	
		ROM Exercise	
		Trach Care/Suctioning	
		Ventilator	
		Other:	

Medical/Nursing Needs

Based on client's overall condition, assessor should evaluate medical and/or nursing needs.

Are there ongoing medical/nursing needs? _____ No 0 _____ Yes 1

If yes, describe ongoing medical/nursing needs:

1. Evidence of medical instability.
2. Need for observation/assessment to prevent destabilization.
3. Complexity created by multiple medical conditions.
4. Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis.

Comments:

Optional: Physician's Signature: _____ Date: _____

Others: _____ Date _____

(Signature/Title)

Client Name: *Client SSN:*

④ PSYCHO-SOCIAL ASSESSMENT

Cognitive Function

Orientation *(Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)*

Person: Please tell me your full mane (so that I can make sure our record is correct).
Place: Where are we now (*state, county, town, street/route number, street name/box number*)? *Give the client 1 point for each correct response.*
Time: Would you tell me the date today *(year, season, date, day, month)*?

_____ Oriented 0
_____ Disoriented – Some spheres, some of the time 1
_____ Disoriented – Some spheres, all the time 2
_____ Disoriented – All spheres, some of the time 3
_____ Disoriented – All spheres, all of the time 4
_____ Comatose 5

Spheres affected: _____

Recall/Memory/Judgment

Recall: I am going to say three words. And I want you to repeat them after I am done (House, Bus, Dog). * Ask the client to repeat them. *Give the client 1 point for each correct response on the first trial.* * Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.

Attention/ Concentration: *Spell the word "WORLD." Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).*

Short-Term: * Ask the client to recall the 3 words he was to remember.

Long-Term: When were you born (What is your date of birth)?

Judgment: If you needed help at might, what would you do?

Optional: MMSE Score
(5)
(5)
(3)
(5)
Total:

Note: Score of 14 or below implies cognitive impairment.

No 0	Yes 1	
_____	_____	Short-Term Memory Loss?
_____	_____	Long-Term Memory Loss?
_____	_____	Judgment Problems?

Behavior Pattern

Does the client ever wander without purpose (trespass, get lost, go into traffic, etc. …) or become agitated and abusive?

_____ Appropriate 0
_____ Wandering/Passive – Less than weekly 1
_____ Wandering/Passive – Weekly or more 2
_____ Abusive/Aggressive/Disruptive – Less than weekly 3
_____ Abusive/Aggressive/Disruptive – Weekly or more 4
_____ Comatose 5

Type of inappropriate behavior: _____ Source of Information: _____

Life Stressors

Are there any stressful events that currently affect your life, such as …?

No 0	Yes 1		No 0	Yes 1		No 0	Yes 1	
_____	_____	Change in work/employment	_____	_____	Financial problems	_____	_____	Victim of a crime
_____	_____	Death of someone close	_____	_____	Major illness- family/friend	_____	_____	Failing health
_____	_____	Family conflict	_____	_____	Recent move/relocation	_____	_____	Other: _____

Client Name:	*Client SSN:*

Emotional Status

In the past month, how often did you …?	Rarely/ Never 0	Some of the Time 1	Often 2	Most of the Time 3	Unable to Assess 9
Feel anxious or worry constantly about things?					
Feel irritable, have crying spells or get upset over little things?					
Feel alone and that you don't have anyone to talk to?					
Feel like you didn't want to be around other people?					
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?					
Feel sad or hopeless?					
Feel that life is not worth living … or think of taking your life?					
See or hear things that other people did not see or hear?					
Believe that you have special powers that others do not have?					
Have problems falling or staying asleep?					
Have problems with your appetite … that is, eat too much or too little?					

Comments:

Social Status

Are there some things that you do that you especially enjoy?

No 0 Yes 1 *Describe*

_____ _____ Solitary Activities _____

_____ _____ With Friends/Family _____

_____ _____ With Groups/Clubs _____

_____ _____ Religious Activities _____

How often do you talk with your children, family, or friends either during a visit or over the phone?

Children	**Other Family**	**Friends/ Neighbors**
_____ No Children 0	_____ No Other Family 0	_____ No Friends/Neighbors 0
_____ Daily 1	_____ Daily 1	_____ Daily 1
_____ Weekly 2	_____ Weekly 2	_____ Weekly 2
_____ Monthly 3	_____ Monthly 3	_____ Monthly 3
_____ Less than Monthly 4	_____ Less than Monthly 4	_____ Less than Monthly 4
_____ Never 5	_____ Never 5	_____ Never 5

Are you satisfied with how often you see or hear from your children, other family, and/or friends?

_____ No 0 _____ Yes 1

Client Name:	*Client SSN:*

Hospitalization/Alcohol – Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves, emotional/mental health, or alcohol/substance abuse problems?

_____ No 0 _____ Yes 1

Name of Place	Admit Date	Length of Stay/Reason

Do (did) you ever drink alcoholic beverages?

_____ Never 0
_____ At one time, but no longer 1
_____ Currently 2
How much: _____
How often: _____

Do (did) you ever use non-prescription, mood-altering substances?

_____ Never 0
_____ At one time, but no longer 1
_____ Currently 2
How much: _____
How often: _____

If the client has never used alcohol or other non-prescription, mood-altering substances, skip to the tobacco question.

Have you or someone close to you, ever been concerned about your use of alcohol/other mood-altering substances?	**Do (did) you ever use alcohol/other mood-altering substances with …**	**Do (did) you ever use alcohol/other mood-altering substances to help you …**
_____ No 0 _____ Yes 1	No 0 Yes 1	No 0 Yes 1
Describe concerns:	_____ _____ Prescription drugs?	_____ _____ Sleep?
	_____ _____ OTC medicine?	_____ _____ Relax?
	_____ _____ Other substances?	_____ _____ Get more energy?
	Describe what and how often:	_____ _____ Relieve worries?
		_____ _____ Relieve physical pain?
		Describe what and how often:

Do (did) you ever smoke or use tobacco products?

_____ Never 0
_____ At one time, but no longer 1
_____ Currently 2
How much: _____
How often: _____

Is there anything we have not talked about that you would like to discuss?

Client Name:	*Client SSN:*

Assessment Summary

Indicators of Adult Abuse and Neglect: *While completing the assessment, if you suspect abuse, neglect, or exploitation, you are required by Virginia law, Section 63.1-55.3, to report this to the Department of Social Services, Adult Protective Services.*

Caregiver Assessment

Does the client have an informal caregiver?

_____ No $_0$ (Skip to Section on Preferences) _____ Yes $_1$

Where does the caregiver live?

_____ With client 0
_____ Separate residence, close proximity 1
_____ Separate residence, over 1 hour away 2

Is the caregiver's help …

_____ Adequate to meet the client's needs? 0
_____ Not adequate to meet the client's needs? 1

Has providing care to client become a burden for the caregiver?

_____ Not at all 0
_____ Somewhat 1
_____ Very much 2

Describe any problems with continued caregiving:

Preferences

Client's preference for receiving needed care: _____

Family/Representative's preference for client's care: _____

Physician's comments (if applicable): _____

Client Name:	*Client SSN:*

Client Case Summary

Unmet Needs

No 0	Yes 1	*(Check All That Apply)*
		Finances
		Home/Physical Environment
		ADLS
		IADLS

No 0	Yes 1	*(Check All That Apply)*
		Assistive Devices/Medical Equipment
		Medical Care/Health
		Nutrition
		Cognitive/Emotional
		Caregiver Support

Assessment Completed By:

Assessor's Name	Signature	Agency/Provider Name	Provider #	Section(s) Completed

Optional: **Case assigned to:** _____ **Code #:** _____

REQUEST FOR PERS
(Personal Emergency Response System)

Recipients cannot have both PERS and Supervision time approved on the same Plan of Care.

Recipient Name:	_____	**Medicaid ID:**	_____
Primary Provider:	_____	**Provider Number:**	_____
PERS Provider:	_____	**Provider Number:**	_____

I. **RECIPIENT COGNITIVE AND PHYSICAL NEEDS WHICH JUSTIFY PERS**

A. **Cognitive Status:** Describe the recipient's cognitive status and impact it has on his/her behavior. If the recipient is confused at different times of the day, please explain. State whether the recipient can/cannot be left alone. If the recipient can be left alone without being a danger to self or others, what is the maximum amount of time that he/she can be left alone? Does the recipient have appropriate judgement/decision making abilities? *(Be as detailed as possible. It is important that the RN make a correct appraisal of the cognitive status of the recipient. Cognitive impairment is defined as a severe deficit in mental capability that affects areas such as thought processes, problem-solving, judgment, memory, or comprehension and that interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, or impulse control.)*

B. **Physical Incapacity:** Describe the degree of physical incapacity and how it creates a need for PERS.

1. Incontinence:
   Bowel: _____ Frequency of Changes: _____
   Bladder: _____ Frequency of Changes: _____
2. Can the recipient change position/shift/transfer without assistance?
3. Skin Breakdown (*Note areas affected/recently documented problems within the last year, including dates*):
4. Potential for skin breakdown (*Based on current condition and frequency of incontinence changing, ability to shift position, history of past skin problems. Note whether the potential breakdown is temporary or ongoing.*):
5. Falls [*Describe any falls that have occurred during the past 3 months, including dates and times of fall(s), and the scenario of the fall(s). Interactions and side effects of medications that may have contributed to the fall(s) must be included. Document what interventions, if any, have been put in place to prevent future falls.*]:

6. Unstable Medical Condition(s) [*List the recipient's current medical diagnoses and needs in relation to any unstable medical condition(s).*]

7. Seizures (*Note the frequency and severity within the past 3 months.*):

8. Mobility (*Note the degree of physical mobility and describe the method of mobility (i.e., wheelchair, ambulation, with/without assistive devices.*):

II. CURRENT SUPPORT SYSTEM

A. Primary Caregiver Information

Name: _____ Home Phone: _____

Does the primary caregiver live with the recipient? ☐ **Yes** ☐ **No**

If no, the caregiver's address: _____

_____

Does the caregiver work out of the home? ☐ **Yes** ☐ **No**

If yes, employer's name: _____ Employer's Phone #: _____

Work Hours: _____

Leave Home: _____ Returns Home: _____

B. List the Support System / Backup System for the primary caregiver. *(The recipient must have a support system if the PERS system becomes disabled. If the recipient is authorized for PERS, it is not necessary for a caregiver to live in the home with the recipient in the absence of a nursing aide. List the names of the persons who are a part of the support system. The provider agency must be able to contact the recipient's support system in case of an emergency.)*

C. The amount of additional support time required that cannot be provided by recipient's support system.
This time is important to ensure that the recipient will not be left with out an active and involved support system.
# of Hours: _____ Between the time of: _____ and _____

_____
Agency / Screening Team

_____ _____
RN Supervisor or PAS Team Member Date

Instructions

If a recipient is requesting PERS (Personal Emergency Response System), the provider must fill this form out completely and submit it to WVMI for authorization. WVMI must approve PERS with an authorization number before DMAS will reimburse for this service.

This form contains patient-identifiable information and is intended for review and use of no one except authorized parties. Misuse or disclosure of this information is prohibited by State and Federal Laws. If you have obtained this form by mistake, please send it to: DMAS, 600 East Broad Street, Suite 1300, Richmond, VA 23219

MI/MR LEVEL I SUPPLEMENT FOR EDCD WAIVER APPLICANTS

A. This section is to be completed by the Pre-admission Screening Committee.

Name: _____ Date of Birth: _____ Date PAS Request Received _____

Social Security No. _____ Medicaid No. _____ Responsible CSB _____

1. DOES THE INDIVIDUAL MEET NURSING FACILITY CRITERIA?

   ☐ Yes ☐ No (Check "Yes" only if both a and b below are answered "Yes".)

   a. Does the individual meet the program criteria for the Elderly or Disabled With Consumer-Direction Waiver AND is the individual at imminent risk? ☐ Yes ☐ No

   b. Can a safe and appropriate plan of care be developed to meet all medical/nursing/custodial care needs? ☐ Yes ☐ No

   (If "Yes", this form must be completed. If "No", do not complete Level I screening and do not refer for assessment of active tx needs. Individuals who do not meet the above criteria cannot be approved for Medicaid funded waiver services.)

2. DOES THE INDIVIDUAL HAVE A CURRENT SERIOUS MENTAL ILLNESS (MI)? ☐ Yes ☐ No
   (Check "Yes" only if answers a, b, and c below are "Yes". If "No", do not refer for assessment of active tx needs for MI Diagnosis.)

   a. Is this major mental disorder diagnosable under DSM-IV (e.g., schizophrenia, mood, paranoid, panic, or other serious anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or other mental disorder that may lead to a chronic disability)? ☐ Yes ☐ No

   b. Has the disorder resulted in functional limitations in major life activities within the past 3-6 months, particularly with regard to interpersonal functioning; concentration, persistence, or pace; and adaptation to change? ☐ Yes ☐ No

   c. Does the treatment history indicate that the individual has experienced psychiatric treatment more intensive than outpatient care more than once in the past 2 years or the individual has experienced within the last 2 years an episode of significant disruption to the normal living situation due to the mental disorder? ☐ Yes ☐ No

3. DOES THE INDIVIDUAL HAVE A DIAGNOSIS OF MENTAL RETARDATION (MR) WHICH WAS MANIFESTED BEFORE AGE 18?
   ☐ Yes ☐ No

4. DOES THE INDIVIDUAL HAVE A RELATED CONDITION? ☐ Yes ☐ No
   (Check "Yes" only if each item below is Checked "Yes". If "No", do not refer for Level II PAS for related condition.)

   a. Is the condition attributable to any other condition (e.g. cerebral palsy, epilepsy, autism, muscular dystrophy, multiple sclerosis, Frederick's ataxia, spina befida), other than MI, found to be closely related to MR because this condition may result in impairment of general intellectual functioning or adaptive behavior similar to that of MR persons and requires treatment of services similar to those for these persons? ☐ Yes ☐ No

   b. Has the condition manifested before age 22? ☐ Yes ☐ No

   c. Is the condition likely to continue indefinitely? ☐ Yes ☐ No

   d. Has the condition resulted in substantial limitations in 3 or more of the following areas of major life activity; self-care understanding and use of language, learning, mobility, self-direction, and capacity for independent living? ☐ Yes (If yes, circle applicable areas) ☐ No

5. RECOMMENDATION (Either "a" or "b" must be checked.)

   a. ☐ Refer for Level II assessment for **:

      ☐ MI (# 2 above is checked "Yes")

      ☐ MR or Related Condition (# 3 or # 4 is checked "Yes")

      ☐ Dual diagnosis (MI and MR/Related Condition categories are checked)

** NOTE: If 5a is checked, the individual may NOT be authorized for Medicaid-funded waiver until the CSB has completed the DMAS-101B.

   b. ☐ No referral for active treatment needs assessment required because individual:

      ☐ Does not meet the applicable criteria for serious MI or MR or related condition

      ☐ Has a primary diagnosis of dementia (including Alzheimer's disease) and does not have a diagnosis of MR

      ☐ Has a primary diagnosis of dementia (including Alzheimer's disease) AND has a secondary diagnosis of a serious MI

      ☐ Has a severe physical illness (e.g. documented evidence of coma, functioning at brain-stern level, or other conditions which result in a level of impairment so sever that the individual could not be expected to benefit from specialized services.)

      ☐ Is terminally ill (note: a physician must have documented that individual's life expectancy is six (6) months or less)

Signature & Title: _____ Screening Committee: _____

Date: _____ Telephone #: _____ Street Address: _____

INSTRUCTIONS FOR COMPLETION OF THE DMAS 101B
PROCESS FOR AUTHORIZING CBC SERVICES FOR PERSONS WITH MI/MR CONDITION

The pre-admission screening team must have this form completed when the person being screened has a condition of mental illness or mental retardation and the person is requesting community-based care services (Personal Care, Adult Day Health Care, Respite Care). Once the screening team determines that the person meets the criteria for CBC services (meets NF or Pre-NF criteria and is at risk of NF placement unless CBC services are offered) the screening team must complete the top portion of the DMAS 101, attach a copy of the UAI and send the two forms to the CSB for an evaluation of the person's need for MH/MR services. This must be done before the screening team completes the DMAS 96 to authorize services.

Any time the screening team has the CSB complete the MH/MR Service Needs Summary Form, *a copy must be attached* to the packet submitted to DMAS for reimbursement and a copy to the Elderly or Disabled With Consumer-Direction Waiver provider if services through this Waiver are authorized.

Assessment of Active Treatment Needs for Individuals with MI, MR, or RC who Request services under the Elder or Disabled with Consumer-Direction Waivers

Attached is an assessment completed by _____ Preadmission Screening Team to determine the need and appropriateness of community-based services under the Elder or Disabled with Consumer-Direction (EDCD) Waiver (personal care, adult day health care, consumer-directed services, and /or respite care) for _____.
(Person Applying for Service)

As part of our assessment process, we have determined that the individual has:
____ *A condition of mental illness which requires assessment for services needed*
____ *A condition of mental retardation which requires assessment for services needed*

Please complete the information below and return it to _____ within 72 hours of
(Name of Screener Making Referral & Phone #)
the date referred _____ so that the assessment and authorization process can be completed.

TO BE COMPLETED BY THE COMMUNITY SERVICES BOARD (Attach additional information as needed.)

The _____ Community Services Board assessed the needs of the individual referenced above on
(Name of CSB)
_____ (*Date assessment completed).*

1. The individual does have a condition of mental illness or mental retardation and has the following active treatment needs:

   _____
   _____
   _____
   _____
   _____

   a. Active Treatment needs will be met by:

   _____
   _____
   _____

   b. If active treatment needs are met by a third party, please attach verification from the third party that all active treatment needs are being met. Also, if active treatment needs are being met by the school system, please explain how active treatment needs will be met during summer vacation:

   _____
   _____
   _____

2. The individual does have a condition of mental illness or mental retardation, but could not benefit from services. Please explain.
   (Note if this block is checked, but there is no explanation, services under the EDCD Waiver cannot be authorized.)

   _____
   _____
   _____

3. The individual does not have a condition of mental illness or mental retardation and therefore does not need treatment or services from the CSB.

Name of individual who completed assessment: (Please print name) _____

Signature of individual who completed assessment: _____

Phone Number: _____ Date Signed: _____

DMAS 101B (revised 10/04)

MEDICAID AIDS WAIVER SERVICES PRE-SCREENING SERVICE PLAN

Recipient Name: _____ Medicaid #: _____

I. SERVICE NEEDS: Note services currently received & who is providing & services needed & potential provider

Service Area	Currently Received	Provider	Service Needed	Refer To Provider
Activities of Daily Living				
Housekeeping				
Living Space				
Meals/Nutritional Supplements				
Shopping/Laundry				
Transportation				
Supervision				
Medicine Administration				
Financial				
Legal Services				
Child Care				
Foster Care				
Dental				
Counseling/Therapy				
Substance Abuse Treatment				
Health Education				
Support Groups				
Attendant Services				
Home Health				
Rehabilitation				
Outpatient Clinic				
Equipment/Supplies				
Physician				
Hospice				
Laboratory Service				
Other				
Other				

II. MEDICAID AIDS WAIVER SERVICES: The following services are authorized to prevent institutionalization

☐ CASE MANAGEMENT Provider: _____ Date Referred: _____

☐ NUTRITIONAL SUPPLEMENTS Physician's Order Attached ☐ Authorization Form to Recipient ☐

☐ PERSONAL CARE Provider: _____ Date Referred: _____

☐ RESPITE CARE Reason Requested: _____

Provider: _____ Type of Respite: ☐ Aide ☐ LPN ☐ RN Date Requested: _____

☐ PRIVATE DUTY NURSING Provider: _____ Date Referred: _____

☐ CD SERVICES Facilitator Agency: _____ Date Referred: _____

I have been informed of the available choice of providers and have chosen the providers noted above:

Medicaid Recipient	Date	PAS Staff	Dater

DMAS-113B (revised 12/02)

NUTRITIONAL STATUS EVALUATION FORM

(This form is required for the provision of enteral nutrition and must be completed as part of a face-to-face nutritional evaluation by a physician, registered nurse, or dietian. Re-evaluations for enteral nutrition via this form are required every 6 months. Instructions for completion are on the reverse side of this form.)

A. PATIENT INFORMATION

Name _____ Date of Birth: _____

Social Security Number: _____ Medicaid Number: _____

B. DATA ELEMENTS

Height: Please complete either a or b below.

a.	Height in inches	b.	Length in inches

Weight: Please complete a, b, and c below.

a.	Current weight in pounds OR		
_____ mid-arm circumference _____ triceps skin fold	Mid-arm circumference (in centimeters) and triceps skin fold thickness 9in millimeters). These measurements are to be used for patients who cannot be feasibly weighed. If known, add measurement for mid arm muscle circumference (in centimeters): _____		
b.	Ideal body weight	c.	Previous or initial weight (if available)

Formula Tolerance: Please check all that apply to the current condition of the patient

a.	Hydrated?	e.	Increased gastric residuals?
b.	Nausea?	f.	Constipation?
c.	Vomiting?	g.	Diarrhea?
d.	Gastric Reflux?	h.	Not currently receiving a formula

Tube or Stoma Site Assessment: Please check all that apply.

a.	Gastrostomy tube?	e.	Stoma site red or irritated?
b.	Nasiogastric tube?	f.	Tube flushes easily?
c.	Other tube?	g.	Fiberous tissue growth?
d.	Leakage present?	h.	Patient complaints?

Date of last tube change: _____

C. THIS NUTRITIONAL SUPPLEMENT IS THE _____ SOLE OR _____PRIMARY SOURCE OF NUTRITION FOR THIS PATIENT (Please check one only; reference instructions on the reverse side of this form)

D. PROGRESS STATEMENT: Base on this evaluation and the plan of care, the patient is (circle one)

1. Stable 2. Progressing toward goal 3. In need of further evaluation

E. COMMENTS

F. PHYSICIAN'S ORDER FOR NUTRITIONAL ASUPPLEMENT: Order must include all the following information:

Begin service date (for this certification period) _____

Category or specific supplement ordered _____ Route of administration _____

Caloric order per day _____ Calories per can/pkg _____

G. WOMEN, INFANTS AND CHILDREN (WIC) PROGRAM COVERAGE (For children under age 5)

Recipient receives _____ cans of _____ type of formula through WIC. There are _____ calories per can of this type of formula, _____ additional calories are required to meet the recipient's needs as prescribed in section F above.

H. ASSESSOR INFORMATION:

Name Title Date

DMAS-115 (revised 10/99)

NUTRITIONAL STATUS EVALUATION FORM (DMAS-l15)

Instructions for Completion

Coverage of enteral nutrition which does not include a legend drug is limited to when the supplement is the sole form of nutrition (except for individuals authorized through the Technology-Assisted or AIDS Waiver or through EPSDT where the supplement must be the primary source of nutrition), is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Coverage of oral administration does not include the provision of "routine" infant formulae.

PATIENT INFORMATION

Enter complete, name, date, of birth, social security number, and Medicaid Number.

B. DATA ELEMENTS

- Height (or length for pediatric recipients);
- Weight: a) either give a current weight or, if unobtainable, must provide mid-arm circumference and triceps skinfold test data. b) Ideal body weight should be recorded from the Weight Status Worksheet. c) For initial assessments, indicate the patient weight Loss over time;
- Formula tolerance (e.g., is the patient experiencing diarrhea, vomiting, constipation). This element is only required if the patient is already receiving a supplement;
- Tube or stoma site assessment, as applicable.

C. PRIMARY OR SOLE SOURCE OF NUTRITION

Sole source means the individual is unable to handle *(swallow* or absorb) any other form of nutrition. Primary source means the nutritional supplements *are* medically indicated for the treatment of the recipient's condition, if the recipient is unable to tolerate nutrients. The patient may either be unable to lake any oral nutrition or the oral intake that can be tolerated is inadequate to maintain life. The focus must be the maintenance of weight and strength commensurate with the patients a condition.

D. PROGRESS STATEMENT

Circle *(ONE*)* appropriate progress statement (For AIDS Waiver recipients, this section is not applicable and may be left blank)

E. COMMENTS

If the client receives nutrition orally or via any other means not addressed on the form, the route of administration must be noted here. This section may also be used to record any other pertinent observations and/or recommendations about the client's nutrition.

F. PHYSICIAN ORDER FOR NUTRITIONAL SUPPLEMENT

This Section must be fully completed in order for the provider of the enteral nutrition to receive reimbursement. The physician's order for all programs must be documented on the DMAS 352 form, Certificate of Medical Necessity (CMN).

G. WOMEN. INFANT AND CHILDREN (WIC) PROGRAM COVERAGE

Complete this section for recipients under age five. The DME provider must have documentation Sn the Women, Infant, and Children Supplemental Food Program (WIC) regarding the extent of coverage of nutritional supplements available through V/IC. Medicaid will only reimburse the DME provider for the portion of the recipient's total caloric order (per the DMA S-115 form, section F) that is not covered *by W.*IC.

H. ASSESSOR INFORMATION

The forms must be competed by a physician, registered nurse, or dietitian. The person completing the form must sign and date the form here. The DMAS-115 must be signed and dated by the assessor (physician, registered nurse, or dietitian) within 60 days of the DMAS-115 begin service date; otherwise, the DMAS-115 will become valid an the date that the form is signed by the assessor.

A copy of the Nutritional Status Evaluation Form, and a copy of the manufacturer's / Supplier's. Invoke must be attached to the HCTA-1500) when billing for HCPCS codes B4154 and B4155.

RESPITE CARE NEEDS ASSESSMENT PLAN OF CARE

WAIVER (Check One): ☐ EDCD ☐ AIDS

A. RECIPIENT NAME: _____ Medicaid No: _____

B. PRIMARY CAREGIVER: _____ Relationship to Recipient: _____

C. STRESSORS: Describe factors that create a need for Respite Care.

Lack of Additional Support: _____

_____

Other Dependents: _____

24-Hour Supervision Required: _____

_____

Illness/Limitations: _____

Other: _____

_____

D. AMOUNT AND TYPE OF RESPITE CARE NEEDED

Reason Respite Care Requested: _____

_____

☐ Routine Hours/day: _____ Days Needed: _____

☐ Episodic Hours/day: _____ Specify Dates Needed: _____

Care must be provided by LPN: ☐ No ☐ Yes Describe Skilled Needed: _____

E. PATIENT PAY

Patient pay information obtained from: _____ _____
Eligibility Worker Phone Number

F. FREEDOM OF CHOICE

In accordance with the policies and procedures of the Department of Medical Assistance Services I have been informed by the Pre-Admission Screening Team of the Medicaid-funded, long term care options available to me by _____ and I choose:
Name of City/County or Hospital

☐ Respite Care Services ☐ Nursing Home Placement

I have been given a choice of the available Respite Care Provider agencies and my choice is _____I understand that only the amount of Respite Care authorized above can be offered. In order to receive Respite Care instead of nursing home care, I understand that the cost to Medicaid for Respite Care (and any additional Medicaid-funded Home and Community-Based Care services) must be equal to or less than the cost to Medicaid for nursing home care. The Pre-Admission Screening team has determined that the above Plan of Care is cost-effective, appropriate to meet my health arid safety needs and necessary to avoid nursing home care.

_____ _____
Physician's Signature & Date Recipient/Family's Signature & Date

ADULT DAY HEALTH CARE INTERDISCIPLINARY PLAN OF CARE

Recipient: _____ Medicaid #: _____

ADHC Name: _____ Provider #: _____

Start of Care Date: _____ Days & Hours of Attendance: _____

SERVICE PROVISION

1. **ADLs** – *(For Each Category Specify Type of Assistance and Frequency)*
   Toileting _____ Eating/Feeding: _____
   Transfer _____ Supervision: _____
   Ambulation _____ Bathing: _____

2. **NUTRITION**
   Meals/Snacks *(Specify frequency, type, special diet, allergy, etc.):* _____
   Nutritional Counseling: _____

3. **NURSING**

Medication	Frequency	Route	Medication	Frequency	Route

   Health Monitoring *(weight, vital signs, fluids, etc.):* _____
   Skilled Services: _____

4. **SOCIALIZATION / RECREATION**
   Counseling with recipient / family *(Specify subject, participants, etc.):*
   Recreational Restrictions: _____
   Socialization Needs: _____

5. **REHABILITATION**
   Therapies *(Specify type, frequency, & provider):* _____

6. **PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)**
   Is the recipient receiving supervision?: ___ Yes ___ No If yes, has he/she been informed of PERS?: ___ Yes ___ No
   Is the recipient receiving PERS?: ___ Yes ___ No **If the recipient has PERS, answer the following questions:**
   Is the recipient 14 years of age or older?: ___ Yes ___ No
   Is the recipient pleased with the service from PERS provider? ___ Yes ___ No

7. **CARE COORDINATOR / CASE MANAGEMENT**
   Recipient's primary caregiver: _____ Phone: _____
   Other service providers: _____

Staff Signature: Date:

Plan of Care Updating / Interdisciplinary Staff Meetings *(All staff initial their Entries)*

Date: _____ Evaluation/Comments: _____

Date: _____ Evaluation/Comments: _____

Date: _____ Evaluation/Comments: _____

Initial	Identifies	Initial	Identifies	Initial	Identifies

DMAS-301
(revised 10/04)

The Virginia Department of Medical Assistance Services:

Questionnaire To Assess An Applicant's Ability to Independently Manage Personal Assistant Services in the Elderly or Disabled With Consumer-Direction (EDCD) Waiver

To The Assessor: In addition to reviewing the applicant's ability to answer questions on the Uniform Assessment Instrument (UAI) regarding his or her status and care needs, question the applicant in the following areas and document the response. **Please note: applicants who have legal guardians or persons who serve as their committee are not eligible for consumer-directed services in the EDCD Waiver.**

- **Daily Decision-Making**

1. Did you pick out the clothes you are wearing? Please explain how you select what clothing you will wear for the day.

_____
_____
_____

2. How do you plan or arrange for your meals? What kinds of things do you eat for breakfast, lunch, and dinner?

_____
_____
_____

3. How do you manage your finances (pay your bills)?

_____
_____
_____

4. What do you do everyday? Please tell me your daily routine.

_____
_____

- **Short- and Long-Range Planning**

1. How often do you have to leave the house? If you do leave the house, how do you make appointments or schedule transportation? What transportation do you use?

_____
_____

The Virginia Department of Medical Assistance Services:

Questionnaire To Assess An Applicant's Ability to Independently Manage Personal Assistant Services in the Elderly or Disabled With Consumer-Direction Waiver (Continued)

- **Short- and Long-Range Planning (Continued)**

2. How do you plan for a future event (for example, Christmas, family visits, etc?)

_____
_____
_____

- **Finding a Personal Assistant**

1. How will you find and hire someone to be your personal assistant? What kind of person will you need to take care of your needs?

_____
_____
_____

2. How will you find a replacement if a personal attendant fails to come to work or quits without notice? How will you manage until you can find another assistant?

_____
_____
_____

3. What would you do to let someone know you needed assistance if your personal assistant does not show up?

_____
_____
_____

4. What steps would you take if your personal attendant was abusive, or you thought the personal attendant was stealing from you?

_____
_____
_____

The Virginia Department of Medical Assistance Services:

Questionnaire To Assess An Applicant's Ability to Independently Manage Personal Assistant Services in the Elderly or Disabled With Consumer-Direction Waiver (Continued)

- **Health Knowledge/Supports**

1. What kind of medical problems do you have? How are you currently taking care of these needs (i.e., are you seeing a doctor?) If you needed to talk to someone about a medical problem, who would you call?

_____
_____
_____
_____

What kind of medications do you take and how often do you take them? What are they for?

_____
_____
_____

2. Who will be providing for your medical needs other than your personal assistant?

_____
_____
_____

- **Support Network**

1. Do you have additional support available from family, neighbors, friends, school or employers who can contact in case you have an emergency? If so, whom? How would you contact them?

_____
_____
_____

The Virginia Department of Medical Assistance Services

Questionnaire To Assess An Applicant's Ability to Independently Manage Personal Assistant Services in the Elderly or Disabled With Consumer-Direction Waiver (Continued)

Pre-Admission Screening Team Recommendation:

_____ **I recommend the applicant receive Consumer-Directed Services (CD) based on: 1) The applicant's demonstrated ability to supervise a personal assistant; and/or 2) The applicant has adequate accommodations/support that enables him or her to manage services independently. The applicant will receive personal assistant management training prior to receiving CD services.**

Additional comments: _____

_____

(This section is applicable for applicants, who are knowledgeable about their own care, can communicate their needs to a personal attendant, and understand the rights, risks, and responsibilities of Medicaid-Funded CD services. The applicant's responses to issues related to daily decision-making, short- and long-range planning, finding an assistant, health knowledge/supports, and support networks demonstrate that the applicant is capable of handling the responsibilities associated with consumer-directed services. Factors which should not influence this decision include, but are not limited to the inability to read and/or write due to a print impairment, educational level, the inability to communicate verbally, or the lack of previous experience in managing his or her health services.)

____ **I do not recommend the applicant receive CD services in the EDCD Waiver PAS. The applicant has little or no knowledge of his or her care requirements and could not assume the responsibilities of consumer-directed services at the present time. The applicant will be offered alternative Medicaid-funded long-term care options.**

Additional comments: _____

_____

(This section is applicable if the applicant has little or no knowledge of his or her care requirements or consumer-directed program responsibilities. Responses in the areas of daily decision-making, short- and long-range planning, finding a personal attendant, health knowledge/supports, or support networks given by the applicant do not demonstrate that the recipient would be capable of meeting program requirements of the EDCD Waiver and successfully managing CD services.)

Assessor Signature: _____ **Date:** _____

A. **This section is to be completed by the Nursing Home Preadmission Screening Committee**.

Name _____ Date of Birth _____ Date NHPAS Request Received _____
Social Security Number Medicaid Number _____ Responsible CSB _____

1. **DOES THE INDIVIDUAL MEET NURSING FACILITY CRITERIA?** ___ yes ____ no (If "yes", this form must be completed If "no", do not complete Level I screening and do not refer for Level II evaluation Individual cannot be admitted to a Medicaid-enrolled nursing facility)

2. **DOES THE INDIVIDUAL HAVE A CURRENT SERIOUS MENTAL ILLNESS (MI)?** _____ yes ("yes" only if a, b, and c below are checked "yes") _____ no (if "no", do not refer for Level II PAS for MI Diagnosis)

   a. Is this major mental disorder diagnosable under DSM-IV (e.g., schizophrenia, mood, paranoid, panic, or other serious anxiety disorder, somatoform disorder; personality disorder, other psychotic disorder; or other mental disorder that may lead to a chronic disability)? ___yes ____ no

   b Has the disorder resulted in functional limitations in major life activities within the past 3-6 months, particularly with regard to interpersonal functioning; concentration, persistence, or pace; and adaptation to change? _____ yes _____ no

   c. Does the treatment history indicate that the individual has experienced psychiatric treatment more intensive than outpatient care more than once in the past 2 years or the individual has experienced within the last 2 years an episode of significant disruption to the normal living situation due to the mental disorder? _____ yes _____ no

3. **DOES THE INDIVIDUAL HAVE A DIAGNOSIS OF MENTAL RETARDATION (MR) WHICH WAS MANIFESTED BEFORE AGE 18?** _____ yes _____ no

4. DOES THE INDIVIDUAL HAVE A RELATED CONDITION? _____ yes ("yes" only if each item below is checked "yes") _____ no (If "no", do not refer for Level II PAS for related condition)

   a. Is the condition attributable to any other condition (e.g., cerebral palsy, epilepsy, autism, muscular dystrophy, multiple sclerosis, Frederick's ataxia, spina bifida), other than MI, found to be closely related to MR because this condition may result in impairment of general intellectual functioning or adaptive behavior similar to that of MR persons and requires treatment or services similar to those for these persons? ____ yes ____ no

   b. Has the condition manifested before age 22? _____ yes _____ no

   c. Is the condition likely to continue indefinitely? _____ yes _____ no

   d. Has the condition resulted in substantial limitations in 3 or more of the following areas of major life activity (circle applicable areas): self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living? _____ yes _____ no

5. **RECOMMENDATION** (Either **"a"** or "b" MUST be checked.)
   a. ☐ Refer for Level II assessment for:
   _____ MI (#2 above is checked "yes")
   _____ MR or Related Condition (#3 or #4 is checked "yes")
   _____ Dual diagnosis (Ml and MR/Related Condition categories are checked)

NOTE: If 5a is checked, the individual may NOT be admitted to a nursing facility until the State Mental Health/Mental Retardation Authority has provided written approval that the individual's needs can be met in the nursing facility.

Date Referral Package Sent _____ Agency Pkg, Sent To: _____
Contact Person _____ Address: _____Phone: _____

   b. ☐ No referral for Level II needed because individual:
   _____ Does not meet the applicable criteria for serious MI or MR or related condition
   _____ Has a primary diagnosis of dementia (including Alzheimer's disease) and does not have a diagnosis of MR
   _____ Has a primary diagnosis of dementia (including Alzheimer's disease) **AND** has a secondary diagnosis of a serious Ml
   _____ Has a severe physical illness (e.g., documented evidence of coma, functioning at brain-stem level, or other conditions which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services)
   _____ Is terminally ill (note a physician must have documented that individual's life expectancy is less than 6 months)

_____ _____ _____
Signature Title Screening Committee

_____ _____ _____
Date Telephone Number Street Address

IDENTIFYING DATA

NAME: Last, first, and middle **DATE OF BIRTH**: Month, date, and year
SOCIAL SECURITY NUMBER: 9-digit number assigned **MEDICAID NUMBER**: 12-digit benefit number assigned
RESPONSIBLE CSB: The Community Services Board in the locality in which the individual resides
DATE NHPAS REQUEST RECEIVED: The date that a request for a Level 1 screening was made

I- Indicate whether the individual meets nursing facility criteria as described in the Virginia Medicaid Nursing Home or Preadmissions Screening Manuals. If "yes" is checked, complete the screening, If the individual does NOT meet nursing facility criteria, do not complete Level I screening and do not refer for Level II evaluation. Level II. If criteria is not met, the individual cannot be admitted to a nursing facility.

2. **Determination of Serious Mental Illness (MI**): Check "yes" (that the individual has a current diagnosis of serious MI) only if *2* a, b, and c are checked "yes". Indicate the diagnosis if "yes' is checked. If "no" is checked for either a, b, or e below, **do not refer for** Level II for MI.

   a. Check "yes' if the individual has a major mental disorder diagnosable under DSM-lll-R (c g, schizophrenia (including disorganized. catatonic, and paranoid types), mood (including bipolar disorder (mixed manic, depressed, seasonal. NOS). major depression (single episode/recurrent, chronic, melancholic or seasonal), depressive disorder MOS, cyclothymia, dysthymia (primary/secondary or early/late onset). Paranoid (including delusional, erotomanic, grandiose, jealous, persecutory, somatic, unspecified, or induced psychotic disorder), panic or other severe anxiety disorder (including panic disorder with agoraphobia. agoraphobia with or without history of panic disorder, social phobia general wed anxiety disorder, obsessive compulsive disorder, past-traumatic stress disorder), somatoform disorder (includes somatization disorder. conversion disorder somatoform pain disorder, hypochondriasis. body dysmorphic disorder, undifferentiated somatotorm disorder, somatoform disorder NOS). Personality disorder (includes paranoid. schizoid. sehizotypal. histrionic, narcissistic, antisocial, borderline. avoidant, dependent. obsessive compulsive, passive aggressive, and NOS), other psychotic disorder (includes schizophreniform disorder. schtizoaffective disorder (bipolar/depressive), brief reactive psychosis, atypical, NOS) or other mental disorder that may lead to a chronic disability)

   b. Check "yes" it the individual has a mental disorder that has resulted in functional limitations in major life activities within the past 3-6 months, particularly with regard to interpersonal functioning concentration, persistence, and pact, arid adaptation **to** change

   e Cheek "yes' tithe individual's treatment history indicates that he or she has experienced (I) psychiatric treatment more intense than outpatient care more than once in the past 2 years or (2) within the last 2 years, an episode of significant disruption to the normal living situation due to the mental disorder

3. Determination of Mental Retardation (MR): Check "yes' if the **individual** has a level of retardation **(mild,** moderate, **severe, or profound)** described in the American Association on Mental Retardation's Manual on Classification In Mental Retardation (19S3) that was manifested before **age 18**

4. **Determination of Related Conditions**: Check 'yes' only if each item in 4 a-d below is checked 11 'no" is checked, do not **refer for Level II** PAS for related conditions

   a. Check 'yes' if the condition is attributable to any other condition (e g, cerebral palsy, epilepsy, autism, muscular dystrophy, multiple sclerosis, Frederick's ataxia, spina bifida), other than MI. found to be closely related to MR because this **condition** may result in impairment of general intellectual functioning or adaptive behavior similar to that of **MR** persons and requires treatment or services similar to those for these persons
   b. Check 'yes" if the condition has manifested before **age 22**
   c. Cheek "yes" if the condition is likely to continue indefinitely
   d. Check "yes' ii the condition has resulted in substantial limitations in 3 or more of the following areas of major life activity self-care. understanding and use of language, learning, mobility, self-direction, and capacity for independent living Circle the applicable areas

5. **RECOMMENDATION** (Either 5a or b MUST be checked)

   a. Cheek this category if Question 2 is checked 'yes' AND/OR either Question 3 or 4 is checked "yes' Indicate whether referral is for MI or MR. the date the package is referred to the CSB, and where and to whom the package is sent An individual for whom 5a has been checked may NOT he admitted to a NF until the State Mental Health/Mental Retardation Authority has determined that NF placement is appropriate

   b. Check this "no referral needed" category ONLY if there is documented evidence as follows
   - Does not meet the 'applicable criteria For MI or MR or a related condition
   - Has a primary diagnosis of dementia (including Alzheimer's disease, (If there is a diagnosis of MR this category does not apply)
   - Has a primary diagnosis of dementia (including Alzheimer's disease) AND a secondary diagnosis of MI
   - Has a severe physical illness (e.g. documented evidence of coma, functioning at brain-stem level, or other diagnoses, which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services. If the answer determines that an illness not listed here is so severe that the individual could not he expected to benefit from specialized services, documentation describing the severe illness must be attached for review)
   - Is terminally ill (note' a physician must have documented that individual's life expectancy is less than 6 months

NOTE: WHEN A SCREENING HAS NOT BEEN PERFORMED PRIOR TO AN INDIVIDUAL'S ADMISSION TO A NF IN A TIMELY MANNER, FEDERAL FINANCIAL PARTICIPATION (FFP) IS AVAILABLE ONLY FOR SERVICES FURNISHED AFTER THE SCREENING', HAS BEEN PERFORMED,

ASSESSOR INFORMATION

SIGNATURE: First Name, Middle initial, and Last Name **TITLE:** Professional title of the assessor
SCREENING COMMITTEE: Name/Locality of screening committee
DATE: Date screening was completed **TELEPHONE NUMBER:** Telephone number, including area code. where assessor may he reached
STREET ADDRESS: Complete Street address, including city-state. and zip code, of the assessor for express mail delivery

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
MI/MR **SUPPLEMENT: LEVEL II**

Name:_____ **Screening Placement Recommendation** _____

B. This section is to be completed by the Community Services Board or other entity **under contract for Level H evaluation process.**

1. EVALUATIONS REQUIRED UPON RECEIPT **OF REFERRAL (Check evaluations submitted upon receipt of** referral)

_____ Neurological Evaluation
_____ Psychological Assessment
_____ Psychiatric Assessment
_____ Psychosocial/Functional Assessment
_____ History and Physical Examination
_____ Other (please specify)_____

2. RECOMMENDATION

_____ Specialized services are not indicated.

_____ Specialized services are indicated.

Comments:_____

_____

_____

_____

3 .Date referral package received: _____ Date package sent to DMRMRSAS: _____

QMHP Signature (MI diagnosis)	**Date**	Telephone Number
Psychologist Signature (MR diagnosis	**Date**	Telephone Number
Case Manager Signature/Title	**Date**	Telephone Number
Agency / Facility Name		Agency / Facility Name ID # (if applicable)
Mailing Address		

C. THIS SECTION IS TO BE COMPLETED ONLY BY THE THE DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES**.**

Date referral package received:_____ Concur with recommendations of specialized services**? ____ yes ____ no**

Comments:

_____

_____

_____

Copies of referral package sent to:	**Representatives Name**	**Date Package Sent**
___ PAS representative		
___ Community Services Board		
___ Admitting/retaining nursing facility		
___ Discharging hospital **(if** applicable		
____ Individual being evaluated		
____ Individual's family		
___ Individuals legal Representative **(if** any)		
___ Attending physician		

Appeals information included.

Signature of State MH/MRA Title Date Telephone Number

MEDICAID FUNDED LONG-TERM CARE SERVICE AUTHORIZATION FORM

I. RECIPIENT INFORMATION:

Last Name: _____ First Name: _____ Birth Date: ___/___/_____

Social Security_____ Medicaid ID _____ Sex: _____

II. MEDICAID ELIGIBILITY INFORMATION:

Is Individual Currently Medicaid Eligible? ☐
- 1 = Yes
- 2 = Not currently Medicaid eligible, anticipated within 180 days of nursing facility admission **OR** within 45 days of application or when personal care begins.
- 3 = Not currently Medicaid eligible, not anticipated within 180 days of nursing facility admission

If no, has Individual formally applied for Medicaid? ☐
0 = No 1 = Yes

Is Individual currently Auxiliary Grant eligible? ☐
- 0 = No
- 1 = Yes, or has applied for Auxiliary Grant
- 2 = No, but is eligible for General Relief

Dept of Social Services:
(Eligibility Responsibility)_____

(Services Responsibility)_____

III. PRE-ADMISSION SCREENING INFORMATION: (to be completed only by Level I, Level II, or ALF screeners)

MEDICAID AUTHORIZATION

Level of Care ☐
- 1 = Nursing Facility Services
- 2 = PACE/LTCPHP
- 3 = AIDS/HIV Waiver Services
- 4 = Elderly or Disabled with Consumer Direction Waiver
- 11 = ALF Residential Living
- 12 = ALF Regular Assisted Living
- 14 = Individual/Family Developmental Disabilities Waiver

NOTE: Authorization for Nursing Facility or the Elderly or Disabled with Consumer Direction Waiver is interchangeable. Screening updates are not required for individuals to move between services because the alternate institutional placement is the same.

NO MEDICAID SERVICES AUTHORIZED
- 8 = Other Services Recommended
- 9 = Active Treatment for MI/MR Condition
- 0 = No other services recommended

Targeted Case Management for ALF ☐
0 = No 1 = Yes

Assessment Completed ☐
1 = Full Assessment 2 = Short Assessment

ALF provider name: _____
ALF provider number: _____
ALF admit date: _____

SERVICE AVAILABILITY ☐
- 1 = Client on waiting list for service authorized
- 2 = Desired service provider not available
- 3 = Service provider available, care to start immediately

LENGTH OF STAY (If approved for Nursing Home) ☐
- 1 = Temporary (less than 3 months)
- 2 = Temporary..(less than 6 months)
- 3 = Continuing (more than 6 months)
- 8 = Not Applicable

NOTE: Physicians may write progress notes to address the length of stay for individuals moving between Nursing Facility and the EDCD Waiver. The progress notes should provided to the local departments of social services Eligibility workers.

LEVEL I/ALF SCREENING IDENTIFICATION

Name of Level I/ALF screener agency and provider number:

1._____

2._____

LEVEL II OR CSB 101B ASSESSMENT DETERMINATION

Name of Level II OR CSB Screener and ID number who have completed the Level II or 101B for a diagnosis of MI, MR, or RC.

1._____

☐
- 0 = Not referred for Level II OR 101B assessment
- 1 = Referred, Active Treatment needed
- 2 = Referred, Active Treatment not needed
- 3 = Referred, Active Treatment needed but individual chooses NH

Did the individual expire after the PAS/ALF Screening decision but before services were received? 1 = Yes 0 = No ☐

SCREENING CERTIFICATION - This authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this recipient.

_____ ___/___/_____
Level I/ALF Screener **Title** **Date**

_____ ___/___/_____
Level I/ALF Screener **Title** **Date**

_____ ___/___/_____
Level I Physician **Date**

DMAS-96 (revised 09/03)

Instructions for completing the *Medicaid Funded Long-Term Care Service Authorization Form* (DMAS-96)

1. Enter Individual's Last Name. **Required.**
2. Enter Individual's First Name. **Required.**
3. Enter Individual's Birth Date in MM/DD/CCYY format. **Required.**
4. Enter Individual's Social Security Number. **Required.**
5. Enter Individual's Medicaid ID number if the Individual currently has a Medicaid card. This number should have either nine or twelve digits.
6. Sex: Enter "F" if Individual is Female or "M" if Individual is Male. **Required.**
7. Is Individual Currently Medicaid Eligible? Enter a "1" in the box if the Individual is currently Medicaid Eligible.

   Enter a "2" in the box if the Individual is not currently Medicaid Eligible, but it is anticipated that private funds will be depleted within 180 days after Nursing Home admission or within 45 days of application or when personal care begins.

   Enter a "3" in the box if the Individual is not eligible for Medicaid and it is not anticipated that private funds will be depleted within 180 days after Nursing Home admission
8. If no, has Individual formally applied for Medicaid? Formal application for Medicaid is made when the Individual or a family member has taken the required financial information to the local Eligibility Department and completed forms needed to apply for benefits. The authorization for long-term care can be made regardless of whether the Individual has been determined Medicaid-eligible, but placement may not be available until the provider is assured of the Individual's Medicaid status.
9. Is Individual currently auxiliary grant eligible? Enter appropriate code ("0", "1" or "2") in the box.
10. Dept of Social Services: The Departments of Social Services with service and eligibility responsibility may not always be the same agency. Please indicate, if known, the departments for each in the areas provided.
11. Assessment Type: Enter in the box the number that corresponds to the assessment provided. If this area is not filled in correctly, payment may not be made, may be delayed, or may be incorrect. **Required.**
12. Medicaid Authorization Enter the numeric code that corresponds to the Pre-Admission Screening Level of Care authorized. Enter only one code in this box.

NOTE: Authorization for Nursing Facility or the Elderly or Disabled With Consumer Direction Waiver is interchangeable. Screening updates are not required for individuals to move between services because the alternate institutional placement is the same.

1 = **NURSING FACILITY** authorize only if Individual meets the Nursing Facility (NF) criteria and community-based care is not an option.

2 = **PACE/LTC PREPAID HEALTH PLAN** authorize only if Individual meets NF criteria (pre-NF criteria does not qualify) and requires a community-based service to prevent institutionalization.

3 = **HIV/AIDS WAIVER** authorize only if Individual meets the criteria for AIDS/HIV Waiver services and requires AIDS/HIV Waiver services to prevent institutionalization (that is, case management, private duty nursing, personal/respite care, nutritional supplements).

4 = **ELDERLY OR DISABLED WITH CONSUMER DIRECTION WAIVER** authorize only if Individual meets NF criteria and requires a community-based service to prevent institutionalization.

11 = **ALF RESIDENTIAL LIVING** authorize only if Individual has dependency in either 1 ADL, 1 IADL or medication administration.

12 = **ALF REGULAR ASSISTED LIVING** authorize only if Individual has dependency in either 2 ADLs or behavior.

14 = **Individual/Family Developmental Disabilities** authorize only if the Individual meets the criteria for admission into an ICF/MR facility and meets the Level of Functioning screening criteria.

If ALF is authorized, enter, if known, in item 29, the provider number of the ALF that will admit the Individual. Enter, in item 27, the date the Individual will be admitted to that ALF.

0 = **NO OTHER SERVICES RECOMMENDED** use when the screening team recommends no services or the Individual refuses services.

8 = **OTHER SERVICES RECOMMENDED** includes informal social support systems or any service excluding Medicaid-funded long-term care (such as companion services, meals on wheels, MR waiver, rehab. services, etc.)

9 = **ACTIVE TREATMENT FOR MI/MR CONDITION** applies to those Individuals who meet Nursing Facility Level of Care but require active treatment for a condition of mental illness or mental retardation and cannot appropriately receive such treatment in a Nursing Facility.

13. Targeted Case Management for ALF ***If ARC, ARR or ARI is authorized***, you must indicate whether Targeted Case Management for ALF (quarterly visits) are also being authorized. The Individual must require coordination of multiple services and the ALF or other support must not be available to assist in the coordination/access of these services. Enter a "0" if only the annual reassessment is required.
14. Service Availability If a Medicaid-funded long-term care service is authorized, indicate whether there is a waiting list (#1) or that there is no available provider (#2), or whether the service can be started immediately (#3).
15. ALF Reassessment: If this is an ALF Reassessment enter the appropriate code for No or Yes. Then mark the appropriate box for a short reassessment or a long reassessment.
16. Length of Stay If approval of Nursing Facility care is made, please indicate how long it is felt that these services will be needed by the Individual. The physician's signature certifies expected length of stay as well as Level of Care.

    NOTE: Physicians may write progress notes to address the length of stay for individuals moving between Nursing Facility or the EDCD Waiver. The progress notes should provided to the local departments of social services Eligibility workers.

17. & 18. Level I/ALF Screening Identification Enter the name of the Level I screening agency or facility (for example, Hospital, local DSS, local Health, Area Agency on Aging, CSB, State MH/MR facility, CIL) and below it, in the 11 boxes provided, that entity's 8-digit provider ID and 3-digit location code.

    For Medicaid to make prompt payments to Pre-Admission Screening committees, all of the information in this section must be completed. *Failure to complete any part of this section will delay reimbursement.*

19. & 20. If the screening is a Nursing Home Pre-Admission Screening completed in the locality, there should be two Level I screeners, both the local DSS and local Health departments. Otherwise, there will only be one Level I screener identification entered.
    Do NOT fill in Lines 16 and 17 or lines 18 and 19 if lines 20 and 21 are filled in. Submit a separate DMAS-96 form.
21. & 22. Level II Assessment Determination If a Level II assessment was performed (MI, MR or Dual), enter the name of the assessor on line 20 and the provider number on line 21. *Do NOT fill in line 20 and 21 if lines 16 and 17 are also filled in*. Submit a separate DMAS-96 form.
23. Enter the appropriate code in the box.
24. When a Screening Committee is aware that an Individual has expired prior to receiving the services authorized by the screening committee, a "1" should be entered in this box.
25. The Level I/ALF Screener must sign and date the form. **Required.**
26. The Level I/ALF Screener must sign and date the form. **Required for all services except ALF placement.**
27. The Level I physician must sign and date the form. **Required for all services except ALF placement.**
28. Enter the date the Individual entered an ALF. Otherwise leave blank. If the Level of Care authorized is NFS, give a copy of this form to the Nursing Facility. The Nursing Facility must enter the date Medicaid Care of the Individual began in this space and place a copy of the form ON TOP of their admission packet.
29. Enter the name of the ALF in which the Individual was placed. Otherwise leave blank. If the Level of Care authorized is NFS, give a copy of this form to the Nursing Facility. The Nursing Facility must enter their name in this space and place a copy of the form ON TOP of their admission packet.
30. Enter the provider number of the ALF in which the Individual was placed. Otherwise leave blank. If the Level of Care authorized is NFS, give a copy of this form to the Nursing Facility. The Nursing Facility must enter their provider number in this space and place a copy of the form ON TOP of their admission packet.

SCREENING TEAM SERVICE PLAN FOR MEDICAID-FUNDED LONG TERM CARE

Individual Being Screened: _____ Medicaid ID#: _____

I SCREENING TEAM DETERMINATION: Refer to Appendix B, NHPAS manual

A. **Individual Meets Nursing Facility Criteria** (Functional Dependency Level and Medical/Nursing Need Present):
□ Yes *(must be checked to authorize Nursing Facility Placement)* □ No

B. **Individual is At Imminent Risk** (within 30 days of application**) of Nursing Facility Placement if Community-Based Care Is Not Offered:** □ Yes □ No

□ Application for the individual to a nursing facility has been made and accepted. Date application was made: _____

Facility: _____ Contact: _____

□ Deterioration in individual's health care condition or changes in available support prevents former care arrangements from meeting needs.
Describe: _____

□ Evidence is available that demonstrates individual's medical and nursing needs are not being met (e.g. Recent doctor's documentation of instability, findings from medical/social service agencies). Describe: _____

Complete Section II ONLY if Nursing Facility Criteria and Risk of Waiver Services Placement are Met

II CHOICE AND PAYMENT RESPONSIBILITY

Medicaid will pay for someone to come into your home to care for you as long as in-home services will safely meet your needs and will not be more expensive than nursing facility care. You may choose to receive in-home services as long as there is an available provider in your area and, either you have some additional support from family, friends, or you are able to manage without additional help when the in-home services are not being provided.

To stay at home, help in the following areas are needed (check as many as needed): □ ADLs □ Housekeeping
□ Meal Preparation □ Shopping □ Laundry □ Supervision *(Attach DMAS-100)* □ PERS *(Attach DMAS-100A)*
□ Transportation □ Skilled Needs

Please identify any people or agencies that are able to provide you with assistance, either on a regular basis or as needed:

People/Agencies	**What Areas of Help Will They Provide**	# Days & Hours/Week

III Recipient Choice to Receive the Following Community-based Care Instead of Nursing Home Care

□ Consumer-Directed Personal Attendant Services (CD-PAS) requested _____ days/week
□ Elderly & Disabled Waiver (E&D)
□ Personal Care services requested _____ days/week.
□ Adult Day Health Care services requested _____ days/week from _____ a.m. to _____ p.m.
□ Both *(ADHC & Personal Care services)* □ Transportation is needed for ADHC services

_____ *(Provider Agency)* has been chosen and contacted and is able to provide the services requested. I understand that the provider will develop a Plan of Care with my assistance based on my needs and my available support. Provider staff is responsible to provide continuous, reliable care, but there may be an occasional lapse in service for which I will need to provide back-up support. (Under Consumer-Directed Personal Attendant Services, I understand the responsibilities associated with employing my own personal attendants). I understand that, based on my income, I may have a co-pay of $_____/month, regardless of the amount of community-based care received.

Client Signature	Date	Screener's Signature	Date

IV Nursing Facility Choice and Payment Responsibility

Community-based care alternatives were explained completely but were not an option for me because _____

□ I choose to receive nursing facility care and requesting admission to _____(facility). I understand that I may have to pay $ _____/ mo. in order to receive nursing facility care. Community-based/in-home care has been explained completely and I understand the options for services that are available? □ Yes □ No

Client's Signature	Date	Screener's Signature	Date

DMAS-97
(revised 12/02)

Instructions For Completing the DMAS-97

Complete this form only if you are authorizing nursing facility or Community-Based Care services.

Section I: Screening Determination

Item A must be checked if authorizing Nursing Facility Placement

Item A or at least one of the conditions in B must be completed if authorizing Community-Based Care Services

Section II: Community Care Choice and Payment Responsibility

Section II must be completed in its entirety if Community Based Care criteria is met and client chooses Community Based Care Services. Please remember to obtain client's signature that assures the client was given a choice of providers and was advised of their possible patient pay responsibility.

The screener must check services that the recipient will need in order to remain at home.

The screening committee must explain to the client that the screening committee does not authorize the amount of services or times of day or days of week on which services will be provided. The provider agency will make that decision with the client based on their needs and wishes identified during the screening.

Section III: Nursing Facility Choice and Payment Responsibility

Section III must be completed in its entirety if Nursing Facility Criteria is met and the recipient chooses Nursing Facility Placement. Please remember to obtain client's signature that assures the client was offered Community-Based Care alternatives and chooses Nursing Facility Placement

VIRGINIA DEPARTMENTS OF MEDICAL ASSISTANCE SERVICES/

SOCIAL SERVICES ASSISTED LIVING FACILITY ELIGIBILITY COMMUNICATION DOCUMENT

To/From: Dept. of Social Services Eligibility Worker in _____
(City/County Responsible for Auxiliary Grant)

Address: _____

To/From:_____
(*ALF Assessor/Case Manager)*

Address: _____

Assessor's provider #: _____

RESIDENT: _____**SSN:** _____

ALF and Location: _____

Medicaid #: _____

PURPOSE OF COMMUNICATION (check 1, 2, or 3):

____ **1.** ***ANNUAL REASSESSMENT COMPLETED ;*** **Date of Reassessment**: ____/_____/_____
- **a.** ____ ***Resident Continues to Meet Criteria for ALF Placement at the following level of care:***
  ___ Residential Living ___ Assisted Living
- **b.** ____ ***Resident Does Not Meet Criteria for Residential or Assisted Living***

____ **2.** ***RESIDENT NO LONGER RESIDES IN ALF ON RECORD***. Resident has been discharged to:
- **a.** ____ ***Another ALF.*** Last Date of Service in the ALF on Record: _____/_____/____
  Name of New ALF : _____
  Provider #: _____ Start of Care Date in New ALF: _____/_____/____
  Address of New ALF:_____
- **b.** ____ ***Home.*** Last Date of Service in the ALF: _____/_____/____
  New Address:_____
- **c.** ____ ***Other*** (please specify): _____
  Last Date of Service in the ALF: _____/_____/____
  New address:_____

____ **3.** ***AUXILIARY GRANT ELIGIBILITY TERMINATED*** Effective Date: _____/_____/_____
Reason:_____

(Name of Assessor/Case Manager Completing Form)		*(Name of Eligibility Worker Completing Form)*	
(Signature of Assessor/Case Manager Completing Form)		*(Signature of Eligibility Worker Completing Form)*	
(Date)	*(Telephone No.)*	*(Date)*	*(Telephone No.)*

ALF ELIGIBILITY COMMUNICATION DOCUMENT INSTRUCTIONS

WHEN TO USE THIS FORM

This form is a communication tool between the local department of social services (LDSS) eligibility worker, the assessor/case manager responsible for the 12-month reassessment of the assisted living facility (ALF) resident, and DMAS. This form is completed by:

1. The assessor to the eligibility worker and to DMAS at the time of a 12-month reassessment (a finding that the resident continues to meet either residential or assisted living is required in order for the eligibility worker to redetermine eligibility for an Auxiliary Grant (AG) payment);
2. Either the assessor or eligibility worker to the other and to DMAS whenever either becomes aware of a change in address; and
3. The eligibility worker to the ALF assessor and to DMAS whenever the AG is terminated.

TO/FROM SECTION

Both TO/FROM sections must be completed. Completely fill in the locality of the DSS eligibility worker with address and indicate whether document is to be sent to or from the eligibility worker by circling "TO" or "FROM." In the second TO/FROM section, completely fill in the assessor's name, address and provider number and indicate whether the document is to be sent to or from the assessor or case manager by circling "TO" or "FROM."

RESIDENT IDENTIFICATION SECTION

1. RESIDENT: Legibly print name of ALF resident who is being assessed, who has moved, or whose AG has been terminated.
2. SSN: Write in the resident's social security number.
3. ALF: Legibly print the name of the ALF in which the resident resides.
4. ALF location: List the city/town in which the ALF is located.
5. Medicaid Number: Write in the resident's Medicaid number.

***PURPOSE OF COMMUNICATION SECTION**:* Check either 1., 2., or 3.

If 1. is checked (Annual Reassessment Completed), fill in the date of the reassessment. Check either a. (Resident continues to meet criteria for ALF placement at the following level of care) or b. (Resident does not meet criteria for residential or assisted living. If a. is checked, indicate which level of care the individual meets. If intensive assisted living is checked, respond to the two questions "continues to need intensive assisted living services" and "based on the UAI, continues to meet criteria for intensive assisted living." Usually, both will be checked "yes." When 1. is checked, the assessor sends a copy of the Uniform Assessment Instrument (UAI), the ALF Eligibility Communication Document (ECD), and the HCFA-1500 to DMAS. In addition, the assessor sends a copy of the ECD to the LDSS eligibility worker; copies of the UAI and ECD to the ALF; and a decision letter to the individual being assessed. The assessor should keep a copy of each of these documents.

NOTE: If a reassessment indicates a change in level of care, treat the assessment as a change in level of care. That is, send a copy of the UAI and the DMAS-96 to DMAS. In addition, send the eligibility worker a copy of the DMAS-96; send to the ALF copies of the UAI, DMAS-96, and decision letter; and send a decision letter to the individual being assessed. The assessor should keep a copy of each.

If 2. is checked (Resident no longer resides in ALF on record), indicate to where the resident moved (i.e., another ACR, home, or other). For each, indicate the last date of service in the ALF on record. Complete other information such as new address, etc., if known. When 2. is checked, the assessor/case manager or eligibility worker completing the ECD should send a copy to the other and a copy to DMAS and keep a copy for him- or herself.

If 3. is checked (Auxiliary Grant Eligibility Terminated), the eligibility worker indicates the effective date of termination and the reason. Then the eligibility worker sends a copy of the ECD to the assessor/case manager and to DMAS.

SIGNATURES SECTION

For each form completed, only one signature section will be completed. For example, if an assessor is completing the form for a reassessment, the left-hand side with assessor information will be completed. If the eligibility worker is completing the form for notification of AG eligibility termination, then the right-hand side is completed. Please completely fill in the applicable section with printed name of individual completing the form, signature, complete date with month/day/year, and telephone number with area code.

Please photocopy this form as needed; plain paper copies are acceptable.

REQUEST FOR SUPERVISION HOURS IN PERSONAL CARE

Recipient Name: _____ **Medicaid ID:** _____

Primary Provider: _____ **Provider Number:** _____

I. RECIPIENT COGNITIVE AND PHYSICAL NEEDS WHICH JUSTIFY NEED FOR SUPERVISION

A. Cognitive Status: **Describe the recipient's cognitive status and impact it has on his/her behavior. If the recipient is confused at different times of the day, please explain. State whether the recipient can/cannot be left alone. If the recipient can be left alone without being a danger to self or others, what is the maximum amount of time that he/she can be left alone? Does the recipient have appropriate judgement/decision making abilities?** ***(Be as detailed as possible. It is important that the RN make a correct appraisal of the cognitive status of the recipient. Cognitive impairment is defined as a severe deficit in mental capability that affects areas such as thought processes, problem-solving, judgment, memory, or comprehension and that interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, or impulse control.)***

B. Physical Incapacity: **Describe the degree of physical incapacity and how it justifies a need for supervision.**

1. Incontinence:

Bowel: _____ **Frequency of Changes:** _____

Bladder: _____ **Frequency of Changes:** _____

2. Can the recipient change position/shift/transfer without assistance?

3. Skin Breakdown (*Note areas affected/recently documented problems within the last year, including dates*):

4. Potential for skin breakdown (*Based on current condition and frequency of incontinence changing, ability to shift position, history of past skin problems. Note whether the potential breakdown is temporary or ongoing.*):

5. Falls [*Describe any falls that have occurred during the past 3 months, including dates and times of fall(s), and the scenario of the fall(s). Interactions and side effects of medications that may have contributed to the fall(s) must be included. Document what interventions, if any, have been put in place to prevent future falls.*]:

C. **The recipient can call (via telephone) for assistance: ☐ Yes ☐ No**

If No, explain: _____

_____

6. **Unstable Medical Condition(s) [*List the recipient's current medical diagnoses and needs in relation to any unstable medical condition(s).*]**

7. **Seizures (*Note the frequency and severity within the past 3 months.*):**

8. **Mobility (*Note the degree of physical mobility and describe the method of mobility (i.e., wheelchair, ambulation, with/without assistive devices.*):**

II. CURRENT SUPPORT SYSTEM

A. Primary Caregiver Information

Name: _____ **Home Phone:** _____

Does the primary caregiver live with the recipient? ☐ Yes ☐ No

If no, the caregiver's address: _____

_____

Does the caregiver work out of the home? ☐ Yes ☐ No

If yes, employer's name: _____ **Employer's Phone #:** _____

Work Hours: _____

Leave Home: _____ **Returns Home:** _____

B. List the Support System / Backup System for the primary caregiver when the Personal Care Aide is absent from the home. Include the name and times the support system is available to assist. ***(The provider must be able to contact the recipient's support system in case of an emergency.)***

C. The amount of time in the Plan of Care for ADL care and Home Maintenance requirements: _____

D. The amount of additional support time required that can not be provided by recipient's support system.

# of Hours: _____ **Between the time of:** _____ **and** _____

_____

Agency / Screening Team

_____ _____

RN Supervisor or PAS Team Member **Date**

Instructions

If a recipient is requesting supervision, the provider must fill this form out completely and submit it to WVMI for authorization. WVMI must approve the request before DMAS will reimburse for this service.

Provider Agency/Consumer-Directed Plan of Care

Recipient Name: _____ Medicaid ID#: _____

Provider Agency/SF: _____ Provider ID#: _____

CHECK EACH TASK TO BE DONE, THEN ENTER THE TOTAL TIME FOR EACH CATEGORY

Categories/Tasks	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1. ADL's Bathing							
Dressing							
Toileting							
Transfer							
Assist Eating							
Assist Ambulate							
Turn/Change Position							
Grooming							
ADL TIME:							
2. Special Maintenance Vital Signs							
Supervise Meds							
Range of Motion							
Wound Care							
Bowel/Bladder Program							
Time:							
3. (PC only) **Supervision Time**							
4. IADLS Meal Preparation							
Clean Kitchen							
Make/Change Beds							
Clean Areas Used by Recipient							
Shop/List Supplies							
Laundry							
(CD only) Money Management							
Medical Appointments							
Work/School/ Social							
IADLS Time:							
Total Daily Time:							

This Section Must Be Completed in its Entirety for Agency & Consumer-Directed Services

Composite ADL Score = (The sum of the ADL ratings that describe this recipient.)

BATHING SCORE		**TRANSFERRING SCORE**	
Bathes without help or with MH only	0	Transfers without help or with MH only	0
Bathes with HH or with HH & MH	1	Transfers w/ HH or w/HH & MH	1
Is bathed	2	Is transferred or does not transfer	2
DRESSING SCORE		**EATING SCORE**	
Dress without help or with MH only	0	Eats without help or with MH only	0
Dresses with HH or with HH & MH	1	Eats with HH or HH & MH	1
Is dressed or does not dress	2	Is fed: spoon/tube/etc.	2
AMBULATION SCORE		**CONTINENCY SCORE**	
Walks/Wheels without help/ w/MH only	0	Continent / incontinent < weekly self care of	
Walks/Wheels w/ HH or HH & MH	1	internal / external devices	0
Totally dependent for mobility	2	Incontinent weekly or > Not self care	2

LEVEL OF CARE: (LOC)	☐ **A** (Score 0 - 6) Maximum Hours of 25/Week	☐ **B** (Score 7 - 12) Maximum Hours 30/Week	☐ **C** (Score 9 + wounds, tube feedings, etc.) Maximum Hours 35/Week

The Amount of Time Needed to Complete All Tasks must Not Exceed The Maximum For the Specified LOC.

RN or SF Signature _____ Date: _____

DMAS-97A&B revised 10/04 (Combined DMAS-97A and 97B)

Recipient Name:	Medicaid ID#:
Provider Agency:	Provider ID#:

Reason Plan of Care Submitted: ☐ New Admission ☐ ↑ In Hours ☐ ↓ In Hours ☐ Transfer

Reason for change/additional instructions for the aide/assistant: _____

_____

Backup Plan/Person (CD Services): _____

Plan of Care Effective Date: _____ Total Weekly Hours: _____

Recipient / Care Giver Signature: _____ Date: _____

RN or SF Signature _____ Date: _____

Instructions for the DMAS-97A/B (10/04)

Provider Notification To Client

This Plan of Care has been revised based on your current needs and available support. If you agree with the changes, no action is required on your part. If you do not agree with the changes, you may contact the RN Supervisor who has signed the plan of care to discuss the reason you disagree with the change.

If the person you contact is unwilling or unable to change the information you disagree with, you have the right to request reconsideration by notifying, in writing, the Community-Based Care Supervisor, WVMI, 6802 Paragon Place, Suite 410, Richmond, Va. 23230. This written request for reconsideration must be filed within thirty (30) days of the time you receive this notification. If you file a request for reconsideration before the effective date of this action, _____ (effective date), and services may continue unchanged during the reconsideration process.

Instructions for Completion of the DMAS-97A/B

Level of Care Determination For Maximum Weekly Hours

Enter a score for each activity of daily living (ADL) based on the client's current functioning. Sum each ADL rating & enter the composite score under the appropriate category: A, B or C. The amount of time allocated under **TOTAL DAILY TIME** to complete all tasks **MUST NOT EXCEED** the maximum weekly hours for the specified LOC.

Provider Notification To Client

Anytime the RN Supervisor or Service Facilitator (SF) changes the plan of care that results in a change in the total number of weekly hours, the RN or SF must complete the entire front section of this form. If the change the agency is making does not require WVMI approval, the RN Supervisor or SF is required to enter the effective date on the Provider Agency Client Notification Section which gives the client their right to reconsideration and make sure the client gets a copy of both the front and back of the form.

WVMI Notification To Client

If the changes to the Plan of Care require WVMI approval, the entire front portion of this form and the DMAS-98 must be completed and forwarded to WVMI for approval. If supervision is requested, please remember to attach the Request for Supervision form (DMAS-100). Supervision is for Agency-Directed Personal Care services only. Once received by WVMI, the analyst will review the care plan and indicate whether the request is pended, approved, or denied. The recipient will receive by mail the decision letter from First Health.

Provider Notification To Client

This Plan of Care has been revised based on your current needs and available support. If you agree with the changes, no action is required on your part. If you do not agree with the changes, you may contact the RN Supervisor who has signed the plan of care to discuss the reason you disagree with the change.

If the person you contact is unwilling or unable to change the information you disagree with, you have the right to request reconsideration by notifying, in writing, the Community-Based Care Supervisor, WVMI, 6802 Paragon Place, Suite 410, Richmond, Va. 23230. This written request for reconsideration must be filed within thirty (30) days of the time you receive this notification. If you file a request for reconsideration before the effective date of this action, _____ (effective date), and services may continue unchanged during the reconsideration process.

Instructions for Completion of the DMAS-97-A

Level of Care Determination For Maximum Weekly Hours

Enter a score for each activity of daily living (ADL) based on the client's current functioning. Sum each ADL rating & enter the composite score under the appropriate category: A, B or C. The amount of time allocated under **TOTAL DAILY TIME** to complete all tasks **MUST NOT EXCEED** the maximum weekly hours for the specified LOC.

Provider Notification To Client

Anytime the RN Supervisor changes the plan of care that results in a change in the total number of weekly hours, the RN must complete the entire front section of this form. If the change the agency is making does not require WVMI approval, the RN Supervisor is required to enter the effective date on the Provider Agency Client Notification Section which gives the client their right to reconsideration and make sure the client gets a copy of both the front and back of the form.

WVMI Notification To Client

If the changes to the Plan of Care require WVMI approval, the entire front portion of this form and the DMAS-98 must be completed and forwarded to WVMI for approval. If supervision is requested, please remember to attach the Request for Supervision form (DMAS-100). Once received by WVMI, the analyst will review the care plan and indicate whether the request is approved or denied. Once the decision is made, the DMAS-98 form will be sent back to the provider agency who is responsible for making sure the client receives a copy of the form which gives the client's right to appeal and the front of the care plan.

Community-Based Care Recipient Assessment Report

☐ Agency-Directed Services ☐ Consumer-Directed Services *Assessment Date:* _____

☐ Initial Visit ☐ Routine Visit ☐ Six-Month Re-assessment

Recipient's Name: _____ Date of Birth: _____

Medicaid ID #: _____ Start of Care: _____

Recipient's Current Address: _____ Agency Name: _____

_____ Provider ID #: _____

Recipient's Phone: (____) _____ Recipient's SSN#: _____

FUNCTIONAL STATUS

ADLs	Needs No Help	MH Only	Human Help		MH & Human Help		Always Performed By Others	Is Not Performed At All
			Supervise	Phys. Asst.	Supervise	Phys. Asst.		
Bathing								
Dressing								
Toileting								
Transferring								
Eating/Feeding								

CONTINENCE	Continent	Incontinent < Weekly	Incontinent Self Care	Incontinent Weekly or >	External Device Not Self Care	Indwelling Cath Not Self Care	Ostomy Not Self Care
Bowel							
Bladder							

MOBILITY

Needs No Help	MH Only	Human Help		MH & Human Help		Confined Moves About	Confined Does Not Move About
		Supervise	Phys. Asst.	Supervise	Phys. Asst.		

ORIENTATION

Oriented	Disoriented-Some Spheres/Sometimes	Disoriented-Some Spheres/All Times	Disoriented-All Spheres/Sometimes	Disoriented-All Spheres/All Times	Semi-Comatose/ Comatose

Spheres Affected: Source of Info:

BEHAVIOR

Appropriate	Wandering/Passive < Than Weekly	Wandering/Passive Weekly or >	Abusive/Aggressive/ Disruptive< Weekly	Abusive/Aggressive/ Disruptive > Weekly	Semi-Comatose/ Comatose

Describe Inappropriate Behavior:

Source of Info:

JOINT MOTION
___ Within normal limits or instability corrected 0
___ Limited motion 1
___ Instability uncorrected or immobile 2

MED. ADMINISTRATION
___ Without assistance 0
___ Administered/monitored by lay person 1
___ Administered/monitored by professional nursing staff 2

MEDICAL/NURSING INFORMATION

Diagnoses: _____

Medications: _____

Current Health Status/Condition: _____

_____

Current Medical Nursing Needs: _____

_____

Therapies/Special Medical Procedures: _____

_____

Hospitalizations: Date(s): _____ Reason(s): _____

_____

Recipient Name: _____ Date of Assessment: _____

SUPPORT SYSTEM

Hours the aide/assistant provides care to the recipient: Total Weekly Hours:_____ Days Per Week:_____
Specific Hours the aide/assistant is in the recipient's home: _____
Other Medicaid/non-Medicaid funded services received:_____
_____
Who is the primary care giver(s): _____
Does the primary care giver live with the recipient: ☐ Yes ☐ No Relationship to recipient: _____
Who other than the recipient is authorized to sign the aide records?_____

CONSUMER-DIRECTED:

Person directing/managing the care: _____ Relationship to recipient: _____
Person providing the care: _____ Relationship to recipient: _____

AGENCY-DIRECTED:

Is the recipient in need of supervision or PERS *(if PERS is a covered service*) at all times to be maintained safely?: ☐ Yes ☐ No
Is the recipient receiving supervision?: ☐ Yes ☐ No If yes, has he/she been informed of PERS (if applicable) ?: ☐ Yes ☐ No
If applicable, is the recipient receiving PERS?: ☐ Yes ☐ No If applicable, is he/she receiving a Medication Monitor?: ☐ Yes ☐ No

<u>If the recipient has PERS, answer the following questions</u>:

Is the recipient 14 years of age or older?: ☐ Yes ☐ No
Is PERS adequate to meet the recipient's needs?: ☐ Yes ☐ No
Is there time when the telephone service is disconnected?: ☐ Yes ☐ No
Is the recipient pleased with the service from PERS provider? ☐ Yes ☐ No

SERVICE FACILITATOR / RN SUPERVISION

Dates of RN supervisory / SF visits for the last 6 months:_____
Frequency of supervisory visits (30 to 90 days): _____
Did the recipient/caregiver agree to frequency of visits, and is it documented in the recipient's file? ☐ Yes ☐ No
Does the aide/personal attendant document accurately the care provided? ☐ Yes ☐ No
Does the Plan of Care reflect the needs of the recipient? ☐ Yes ☐ No
If No to either, please describe follow-up: _____
_____

CONSISTENCY AND CONTINUITY

Number of days of no service in the last 6 months: (Do not include hospitalizations) _____
Number of aides assigned to the case in the last 6 months: Regular Aides: _____ Sub-Aides: _____
Has the recipient or caregiver had any problems with the care provided in the last six months? ☐ Yes ☐ No If yes, please describe problem(s) and the follow-up taken: _____
_____
Is the recipient satisfied with the service he/she is receiving by the provider agency?: ☐ Yes ☐ No If no, please describe and the follow-up taken: _____
_____

Date of most recent DMAS-122: _____ Patient Pay Amount (if applicable): _____

Aide / Attendant Present During Visit? ☐ Yes ☐ No Name of Aide: _____
Regular Aide/Attendant ☐ OR Sub Aide/Attendant☐

SF / NURSING NOTES: _____

RN / SF SIGNATURE: _____ **DATE:** _____

INSTRUCTIONS FOR COMPLETION OF THE DMAS-99

Agency-directed services must have use this form for all RN supervisory visits conducted for Personal and Respite Care services. The instruction for filling out the DMAS-99 may vary with the type of visit that is conducted. Check the appropriate box at the top of page one. Whether the service is agency-directed or consumer-direct, the Initial and the Six-Month Re-assessment visit require the entire DMAS-99 to be filled out completely. The Routine Supervisory Visit may allow an update of the previous routine supervisory visit's information.

Detailed instructions for filling out the DMAS-99 for agency-directed and consumer-directed services are provided below. If you have further questions, please call the Waiver Services Unit for assistance at (804) 786-1465.

AGENCY-DIRECTED SERVICES
THE INITIAL AND SIX-MONTH REASSESSMENT VISIT

It must include: the recipient's name, address, date of birth, phone number, Medicaid ID number, the start of care date, and the provider agency's name and provider number.

FUNCTIONAL STATUS: Must be completed in detail on the initial visit and during the six-month reassessment visit. The recipient's dependence or independence in an ADL should be noted by placing a check mark in the appropriate box under each category. Apply the definitions provided in the Virginia Uniform Assessment Instrument (UAI) user's manual when assessing the recipient and completing this section. If there is any doubt in the recipient's ability to perform a task, the RN should ask the recipient to demonstrate the completion of that task. Shaded areas indicate the recipient is independent in that function. "Independent" means that the recipient does not need an aide to assist with any part of the task. Under JOINT MOTION, it should be noted which joints are limited (if applicable). Under MED. ADMINISTRATION, note who administers the recipient's medications.

MEDICAL/NURSING INFORMATION: All of these blanks must be completed on the Initial and Six-month assessments. DIAGNOSES- All diagnoses contributing to the health needs of the recipient should be noted on this visit. Remember that the recipient may have developed another medical complication requiring the documentation of another diagnosis. MEDICATIONS: List the individual's medications. CURRENT HEALTH STATUS/CONDITION- Note information such as weight loss or gain (if pertinent), medication changes, MD visits, including for what reason, and whether the recipient's condition has improved, declined, or remained stable. The RN must assess this issue by asking pointed questions, (e.g., have you seen the doctor since I was here last time? Did the doctor change your medication? Have you been having any dizzy spells? Have you been able to eat all of your meals without vomiting afterward? Are you still having headaches? Are you checking your sugar four times a day?). CURRENT MEDICAL NURSING NEEDS- Include any information that should be monitored by the RN or the doctor, such as, blood sugar levels, wounds, weight loss, malnutrition, dehydration, respiratory distress, immobility issues, circulatory problems, blood-work for medication adjustments. This is not asking for a summary of the recipient's ADL functioning. THERAPIES / SPECIAL MEDICAL PROCEDURES- This must be addressed on the initial assessment and six-month reassessment. Therapies may include PT, ST, and OT while special medical procedures may include range of motion, bowel and bladder programs, and wound care. If the recipient is receiving Home Health skilled services, note frequency of visits, the agency providing services, and the reason(s) & disciplines for visits. HOSPITALIZATIONS- Include the dates of admission and discharge, and the reason(s) for the admission.

SUPPORT SYSTEM: Must be completed in detail on these visits. Any changes in the hours on the Plan of Care, support system and/or the need for supervision should be noted. TOTAL WEEKLY HOURS AND DAYS PER WEEK- This should reflect the hours and days on the current plan of care. OTHER MEDICAID/NON FUNDED SERVICES- List those that the recipient is receiving, which may include, but not be limited to, Meals on Wheels, companion services, Adult Day Health Care, and etc. WHO WILL BE RESPONSIBLE FOR SIGNING THE AIDE RECORDS- If the recipient is cognitively impaired, note who this includes, i.e., family, friends and/or significant other. If someone other than the recipient will be signing the aide record, that person should be instructed to sign his/her own name, not the recipient's name. If the person signing the aide record(s) is not the primary caregiver, the nurse should note on the DMAS-99 that this person has authorization to sign for the recipient. IS THE RECIPIENT IN NEED OF SUPERVISION- If the supervision is provided solely by the recipient's caregivers, the Request for Supervision Form is *not* required. If, however, supervision hours are provided on the recipient's plan of care, the Request for Supervision Form (DMAS 100) must be on file in the recipient's record. If the recipient requires supervision at all times and the caregivers are not available at all times, has the recipient been informed about the Personal Emergency Response System (PERS), if it is a covered service in the waiver? The recipient must be assessed to determine there are no cognitive deficits in order for PERS to be used appropriately. If the recipient has PERS, the related questions in this section must be answered.

RN SUPERVISION: Dates of RN supervisory visits for the last six months must be completed on the six - month reassessment. The accuracy of the aide documentation must be noted with every routine supervisory visit and should directly correlate with whether the aide is following the recipient plan of care, or if not, documenting the reason for not following the plan of care. The Frequency of the supervisory visit that was agreed upon between the RN and the recipient must be documented. This frequency can be from 30 to 90 days, for recipients without a cognitive impairment as defined by DMAS policy. If the RN's plan of care is not being followed by the aide due to inaccuracies on the plan of care, or the plan of care is not meeting the recipient's needs, answer one or both questions as "NO". Any **"NO" answers** must be explained including how the plan of care will be changed to meet the recipient's needs.

CONSISTENCY AND CONTINUITY: The number of no service days within the last six months must be indicated on the six-month reassessment. Do not include days the recipient/caregiver requested to be without service or days the recipient was hospitalized. Note how many aides have been assigned over the past six months as well as how many substitute aides were utilized. If the recipient or caregiver(s) has been dissatisfied with the aide, RN, agency, or hours, describe the problem and the follow-up taken. (An additional page may be attached if needed).

Record the date and patient pay amount (if applicable) from the most recent DMAS 122.

The RN/Coordinator should sign his/her full name and title clearly and legibly and include the date the home visit was conducted. DMAS will look for the date by the RN's signature when conducting utilization review. The DMAS-99 must be filed in the recipient's record within five days of the date of the last visit. If an aide was present in the home at the time of the visit, note the aide's full name and whether the aide is regularly assigned or is being utilized as a substitute aide on this day.

NURSING NOTES: Nurses may utilize this space for documentation of pertinent issues that may occur between the current home visit and the next home visit. Additional paper may also be attached if needed.

AGENCY-DIRECTED ROUTINE RN SUPERVISORY VISITS:

The recipient's address, date of birth, start of care date, and phone number may be omitted on the routine reassessment, if desired.

FUNCTIONAL STATUS: If the RN determines that there has been no change in the functional status, a line may be drawn through all of the Functional Status boxes and "No Change" written.

MEDICAL/NURSING INFORMATION: This area must be completed on every ROUTINE visit. If the diagnoses have not changed, NO CHANGE may be written on this line during the ROUTINE visit. New diagnoses may be added as indicated on the ROUTINE reassessment note. Current health status/condition must be addressed on every routine supervisory visit and note information such as weight loss or gain (if pertinent) medication changes, MD visits-including for what reason, and whether the recipient's condition has improved, declined, or remained stable since the last reassessment. Current Medical Nursing Needs, must be updated on the ROUTINE reassessment note if indicated. Medical Nursing Needs must be present if the recipient meets the nursing facility criteria. Therapies/Special Medical Procedures: Therapies may include PT, ST, and OT while special medical procedures may include range of motion, bowel and bladder programs, and wound care. If the recipient is receiving Home Health, note frequency of visits, agency providing services, and reason for visits. Hospitalizations: Include the dates of admission and discharge, and the reason for the admission.

SUPPORT SYSTEM: Any changes regarding hours on the plan of care, support system and/or need for supervision should be noted. Total Weekly Hours and Days per Week should reflect the hours and days on the current plan of care. Other Medicaid/Non Funded Services the recipient is receiving may include (but not be limited to) meals on wheels, companion services, Adult Day Health Care, and etc. If the recipient is cognitively impaired, who will be responsible for signing the aide records must be noted and may include family, friends and/or significant other. If the recipient is in need of supervision at all times but supervision is provided solely by the recipient's caregivers, the Request for Supervision Form is *not* required. If supervision hours are provided on the recipient's plan of care, the Request for Supervision Form (DMAS 100) must be on file in the recipient's record. If the recipient requires supervision at all times but caregivers are not available at all times, has the recipient been informed about PERS, if it is a covered service in the waiver? The recipient must be assessed to determine there are no cognitive deficits in order for PERS to be used appropriately. If the recipient has PERS, the related questions in this section must be answered.

RN SUPERVISION: The accuracy of the aide documentation must be noted on every routine supervisory visit and should directly correlate with whether the aide is following the recipient plan of care, or if not, documenting the reason(s) for not following the plan of care. If the RN's plan of care is not being followed by the aide due to inaccuracies on the plan of care, or the plan of care is not meeting the recipient's needs, answer one or both questions as "NO". Any **"**NO" answers must be explained including any changes to the plan of care to meet the recipient's needs.

CONTINUITY & CONSISTENCY: If the recipient or caregiver(s) has been dissatisfied with the aide, RN, agency, or hours, describe the problem and the follow-up taken. (An additional page may be attached if needed).

Note the date and patient pay amount (if applicable) from the most recent DMAS 122**.**

The RN/Coordinator should sign his/her full name and title clearly and legibly and include the date the home visit was conducted. DMAS will look for the date by the RN's signature when conducting utilization review. The DMAS-99 must be filed in the recipient's record within five days of the date of the last visit. If an aide was present in the home at the time of the visit, note the aide's full name and whether the aide is regularly assigned or is being utilized as a substitute aide on this day.

NURSING NOTES: Nurses may utilize this space for documentation of pertinent issues that may occur between the current home visit and the next home visit. Additional paper may also be attached if needed.

CONSUMER-DIRECTED SERVICES
THE INITIAL AND SIX-MONTH REASSESSMENT VISIT

It must include: the recipient's name, address, date of birth, phone number, Medicaid ID number, the start of care date, and the provider agency's name and provider number.

FUNCTIONAL STATUS: Must be completed in detail on the initial visit and during the six-month reassessment visit. The recipient's dependence or independence in an ADL should be noted by placing a check mark in the appropriate box under each category. Apply the definitions provided in the Virginia Uniform Assessment Instrument (UAI) user's manual when assessing the recipient and completing this section. If there is any doubt in the recipient's ability to perform a task, the CDSF should ask the recipient to demonstrate the completion of that task. Shaded areas indicate the recipient is independent in that function. "Independent" means that the recipient does not need an aide to assist with any part of the task. Under JOINT MOTION, it should be noted which joints are limited (if applicable). Under MED. ADMINISTRATION, note who administers the recipient's medications.

MEDICAL/NURSING INFORMATION: All of these blanks must be completed on the initial and six-month assessments. DIAGNOSES- All diagnoses contributing to the health needs of the recipient should be noted on this visit. Remember that the recipient may have developed another medical complication requiring the documentation of another diagnosis. CURRENT HEALTH STATUS/CONDITION- Note information such as weight loss or gain (if pertinent), medication changes, MD visits, including for what reason, and whether the recipient's condition has improved, declined, or remained stable. The CDSF must assess this issue by asking pointed questions, (e.g., have you seen the doctor since I was here last time? Did the doctor change your medication? Have you been having any dizzy spells? Have you been able to eat all of your meals without vomiting afterward? Are you still having headaches? Are you checking your sugar four times a day?). CURRENT MEDICAL NURSING NEEDS- Include any information that should be monitored by the CDSF or the doctor, such as, blood sugar levels, wounds, weight loss, malnutrition, dehydration, respiratory distress, immobility issues, circulatory problems, blood-work for medication adjustments. This is not asking for a summary of the recipient's ADL functioning. THERAPIES / SPECIAL MEDICAL PROCEDURES- This must be addressed on the initial assessment and six-month reassessment. Therapies may include PT, ST, and OT while special medical procedures may include range of motion, bowel and bladder programs, and wound care. If the recipient is receiving Home Health skilled services, note frequency of visits, the agency providing services, and the reason(s) & disciplines for visits. HOSPITALIZATIONS- Include the dates of admission and discharge, and the reason(s) for the admission.

SUPPORT SYSTEM: Must be completed in detail on these visits. Any changes in the hours on the Plan of Care or the support system should be noted. TOTAL WEEKLY HOURS AND DAYS PER WEEK- This should reflect the hours and days on the current plan of care. OTHER MEDICAID/NON FUNDED SERVICES- This must be filled out. PERSON PROVIDING THE CARE- If the recipient has someone managing his/her POC, the person's full name. PERSON DIRECTING THE CARE – The full name of the personal assistant providing the care. The person directing the care and the assistant cannot be the same person.

SERVICE FACILITATOR SUPERVISION: Dates of Facilitator's supervisory visits for the last six months must be completed on the six-month reassessment. Document if the attendant is following the recipient plan of care, or if not, documenting the reason for not following the plan of care. If the Facilitator's plan of care is not being followed by the attendant due to inaccuracies on the plan of care, or the plan of care is not meeting the recipient's needs, answer "NO", and explain, including how the plan of care will be changed to meet the recipient's needs if it needs to be.

CONSISTENCY AND CONTINUITY: The number of no service days within the last six months must be indicated on the six-month reassessment. Do not include days the recipient/caregiver requested to be without service or days the recipient was hospitalized. Note how many attendants have been assigned over the past six months as well as how many substitute attendants were utilized. If the recipient or caregiver(s) has been dissatisfied with the attendant, service facilitator, facilitator agency, or hours, describe the problem and the follow-up taken. (An additional page may be attached if needed).

Record the date and patient pay amount (if applicable) from the most recent DMAS 122.

The Facilitator should sign his/her full name and title clearly and legibly and include the date the home visit was conducted. DMAS will look for the date by the Facilitator's signature when conducting utilization review. The DMAS-99B must be filed in the recipient's record within five days of the date of the last visit. If an attendant was present in the home at the time of the visit, note the attendant's full name and whether the attendant is regularly assigned or is being utilized as a substitute attendant on this day.

SERVICE FACILITATOR NOTES: Utilize this space for documentation of pertinent issues that may occur between the current home visit and the next home visit. Additional paper may also be attached if needed.

CONSUMER-DIRECTED ROUTINE FACILITATOR SUPERVISORY VISITS:

The recipient's address, date of birth, start of care date, and phone number may be omitted on the routine reassessment, if desired.

FUNCTIONAL STATUS: If it is determined that there has been no change in the functional status, a line may be drawn through all of the Functional Status boxes and "No Change" written.

MEDICAL/NURSING INFORMATION: This area must be completed on every ROUTINE visit. If the diagnoses have not changed, NO CHANGE may be written on this line during the ROUTINE visit. New diagnoses may be added as indicated on the ROUTINE reassessment note. Current health status/condition must be addressed monthly and note information such as weight loss or gain (if pertinent) medication changes, MD visits-including for what reason, and whether the recipient's condition has improved, declined, or remained stable since the last reassessment. Current Medical Nursing Needs, must be updated monthly on the ROUTINE reassessment note if indicated. Medical Nursing Needs must be present if the recipient meets the nursing facility criteria. Therapies/Special Medical Procedures: Therapies may include PT, ST, and OT while special medical procedures may include range of motion, bowel and bladder programs, and wound care. If the recipient is receiving Home Health, note frequency of visits, agency providing services, and reason for visits. Hospitalizations: Include the dates of admission and discharge, and the reason for the admission.

SUPPORT SYSTEM: Any changes regarding hours on the plan of care or the support system should be noted. Total Weekly Hours and Days per Week should reflect the hours and days on the current plan of care. Other Medicaid/Non Funded Services should be filled out.

SERVICE FACILITATOR SUPERVISION: document if the attendant is not following the plan of care and the reason(s) why. If the Facilitator's plan of care is not being followed by the attendant due to inaccuracies on the plan of care, or the plan of care is not meeting the recipient's needs, answer "NO", and explain, including how the plan of care will be changed to meet the recipient's needs if it needs to be.

CONTINUITY & CONSISTENCY: If the recipient or caregiver(s) has been dissatisfied with the attendant, service facilitator, facilitator agency, or hours, describe the problem and the follow-up taken. (An additional page may be attached if needed).

Note the date and patient pay amount (if applicable) from the most recent DMAS 122**.**

The facilitator should sign his/her full name and title clearly and legibly and include the date the home visit was conducted. DMAS will look for the date by the facilitator's signature when conducting utilization review. The DMAS-99B must be filed in the recipient's record within five days of the date of the last visit. If an attendant was present in the home at the time of the visit, note the attendant's full name and whether the attendant is regularly assigned or is being utilized as a substitute attendant on this day.

SERVICE FACILITATOR NOTES: Utilize this space for documentation of pertinent issues that may occur between the current home visit and the next home visit. Additional paper may also be attached if needed.

ADULT DAY HEALTH CARE DAILY LOG

Recipient's Name: _____ Medicaid ID: _____

DAY:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
DATE (Month/Day/Year):	/ /	/ /	/ /	/ /	/ /	/ /	/ /
ACTIVITY:							
Toileting							
Ambulation/Transfer							
Eating/Feeding							
Supervision							
Meals/Snacks							
Nutritional Counseling							
Administer Medication							
Health Monitoring							
Skilled Services							
Social/Rec. Activities							
Rehab. Support							
Transportation							
Other							
DAILY TIME IN							
DAILY TIME OUT							
NUMBER OF HOURS							

Weekly Comments & Date: _____

_____

_____

_____

Weekly Signatures:

_____ _____

Recipient/Family's Signature Date ADHC Staff Signature Date

DMAS-302
(revised 10/04)

This form contains patient-identifiable information and is intended for review and use of no one except authorized parties. Misuse or disclosure of this information is prohibited by State and Federal Laws. If you have obtained this form by mistake, please send it to: DMAS, 600 East Broad Street, Suite 1300, Richmond, VA 23219